NAVMED P-5084

GUIDE FOR MEDICAL PERSONNEL AUGMENTING FLEET MARINE AND AMPHIBIOUS FORCES

BUREAU OF MEDICINE AND SURGERY
DEPARTMENT OF THE NAVY

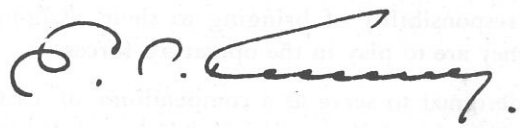
Return - Due to revision 3/25/71

FOREWORD

For some time we at the Bureau of Medicine and Surgery have seen the dire need for a comprehensive collection of data which might be used as a reference by the Surgical Teams, Casualty Evacuation Teams, and Fleet Marine and Amphibious Force Augmentation Personnel.

The "Augmentation Plan" will, we believe, satisfy the needs of the Operating Forces in the medical support of amphibious operations of the Navy and Marine Corps. It also will provide this same support in national emergencies and disasters.

This brochure is a result of collaborative effort between the Bureau of Medicine and Surgery and the Staff Medical Officers of the Fleet and Marine Corps. Additional assistance was given by members of the Surgical Teams. We are deeply appreciative of the assistance given in making this work possible.



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PREFACE

The primary responsibility of the Medical Department of the Navy is to support medically the operating forces. These forces are not staffed with sufficient medical personnel during peacetime to meet their medical obligations under combat conditions. Therefore, medical personnel working in the Shore Establishment can expect to be designated to augment the operating forces when these forces are ordered into combat. There are three (3) augmentation categories:

a. Surgical Teams

b. Casualty Evacuation Teams

c. Fleet Marine Force and Amphibious Force Augmentation Personnel

Every member of the Medical Department should fully understand this concept and recognize that it is the responsibility of the Bureau of Medicine and Surgery to provide this kind of support.

Those in command of medical personnel who have been designated to augment the operating forces have a responsibility to insure that those individuals designated are fully qualified and, more importantly, are prepared to respond at a moment's notice. Those who are selected for augmentation duty have the responsibility of bringing to their assignment a full understanding of their orders and the role they are to play in the operating forces.

This brochure is designed to serve as a compendium of useful information for the guidance of medical personnel in our hospitals, station hospitals and dispensaries who are selected for augmentation and deployment to the operating forces. The contents included herein have been checked for accuracy and completeness by officers well versed in the subject matter under discussion. In addition, pertinent Navy Regulations and other information important to the augmentation program have been added in the form of appendices.

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ILLUSTRATIONS

THE ORGANIZATION OF THE MARINE DIVISION

1. A Marine Division is a complex structure of approximately 18,000 men. For simplicity, it can be divided into two parts:

a. Combat Units

b. Support Units

2. The Division is divided into three Infantry Regiments, one Artillery Regiment, and seven Support Battalions, one of which is the Medical Battalion. A Marine Infantry Regiment consists of approximately 3,500 men and is further subdivided into three Infantry Battalions and a Regimental Headquarters Company.

3. A Marine Infantry Battalion consists of approximately 1,000 men and is further subdivided into five companies. Four of these companies are the rifle companies for the infantry units. The remaining company is the Headquarters and Service Company which includes the Battalion Staff, the personnel to man the Command Post, and certain centralized combat groups (such as flame throwers, etc.) to be attached to the individual line companies on an "as-needed" basis. Each rifle company has about 200 men, whereas the Headquarters and Service Company has about 300 men. The Battalion Aid Station is part of this latter company, and is set up in the area of the Battalion Command Post.

4. The Separate or Support Battalions consist of miscellaneous battalions of markedly varying sizes. These battalions are able to supply many different types of support. The Medical Battalion, to which the Surgical Team would be attached, has a total of 446 officers and men. Of this number, 48 are Naval Officers, three are Marine Officers, and 272 are Navy enlisted and 123 Marine enlisted.

5. Unlike the infantry battalion and regiment which essentially maintains its organic integrity, support battalions often send out detachments of themselves to be attached to the commands of the various combat units. With the completion of its mission, the attached unit will revert to the parent organization from which it was derived. In this way, a collecting and clearing company—one of four such units in the Medical Battalion—will be assigned to support an infantry regiment, and provide a nucleus of medical support and evacuation for the many medical aid stations in the regiment. Thus, the collecting and clearing company could at one time support between 3,000 and 4,000 men.

6. You will hear of other teams such as "Battalion Landing Team (BLT)" and "Regimental Landing Team (RLT)". These are nothing more than the reinforced infantry battalions or regiments with the attached units of the support battalions. Such a team is said to be "Reinforced." Another term you may hear is "Brigade." A Brigade is a special combat unit, quite variable in size though usually larger than a Regimental Landing Team.

7. In actual combat, other Marine organizations will support the division. The Marine Air Wing may provide helicopters, fixed wing transports, or tactical aircraft. The force troops may supply heavy tanks, engineers, amphibious armored tractors, or additional medical units. And finally, the landing will be supported by the various seaward tactical and support elements of the Navy.

MEDICAL UNITS IN SUPPORT OF THE DIVISION

In general, Medical Department personnel serving with the Fleet Marine Force may be divided, according to functions performed in the field, into two groups:

1. Combat elements which provide medical care or initial first aid to prepare the casualty for further evacuation.

2. Supportive elements which provide surgical and medical aid to those who need early definitive care and cannot be further evacuated.

Medical personnel are a permanent part of the combat element to which they are assigned; they train with their units, live with and accompany them at all times.

Infantry Regiment

In an infantry regiment there are seven medical officers and 161 hospital corpsmen. The headquarters company of the regiment has one Medical officer (the Regimental Surgeon) and two Hospital corpsmen. This section establishes a

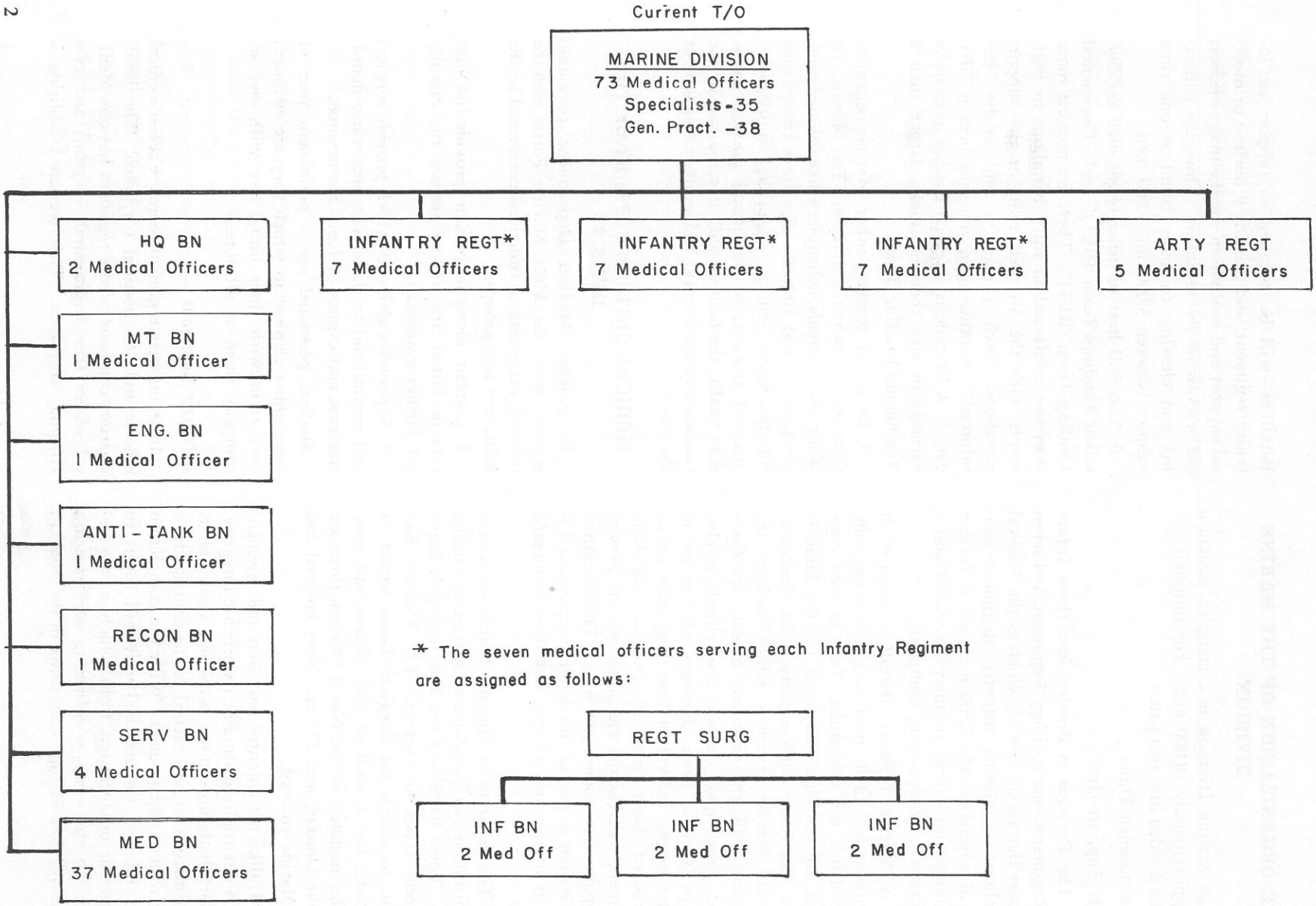


Figure 1. Current Table of Organization of a Marine Division and Supporting Medical Units

small aid station in the region of the regimental command post. One corpsman is an aidman, the other is a sanitation technician whose duties consist of supervising and coordinating the sanitation procedures conducted within the regiment.

Infantry Battalion

The infantry battalion medical section is composed of two medical officers and 53 corpsmen. Thirty two of this number are assigned as company aidmen. They accompany the rifle company, to which they are assigned, at all times and in all situations. The remaining 21 are assigned to the battalion aid station which is established and maintained in the rear of the front line troops and, which is under the direction of the Medical officers assigned to the battalion. Here all casualties are received which were cared for initially by the aidmen with the rifle companies (eight corpsmen/Rifle Company), and here they are re-examined and decisions made as to their treatment and disposition.

Artillery Regiment and Artillery Battalion

Artillery regimental and battalion medical sections are similar in organization and function to those of the infantry. However fewer personnel are assigned because they are not located as near the enemy. Aid stations are set-up in the area of the regimental and battalion command posts and, in addition, two Hospital corpsmen are assigned to each firing battery.

Medical Sections of Separate Battalions of the Marine Division

Separate battalion medical sections vary in size depending upon the size of the battalion with which they serve. These battalions are the (1) Headquarters Battalion, (2) Service Battalion, (3) Motor Transport Battalion, (4) Medical Battalion, (5) Pioneer Battalion, (6) Reconnaissance Battalion, and (7) Antitank Battalion. In view of the fact that detachments of these battalions are assigned to operate in the support of the infantry, the casualties from these detachments that occur during an engagement are handled through the infantry battalion medical sections. The main effort of the separate battalion medical section is directed toward setting up an aid station in the area of their battalion command post with medical personnel, as needed, being assigned to small detachments operating independently of the battalion.

Medical Units of the Shore Party

The shore party medical sections that support regiments and battalions at the landing beaches and helicopter landing zones may vary in size, depending upon the particular mission, and have as their function the establishing and operating of the shore party evacuation stations on each landing beach or helicopter landing zone. They facilitate the actual transfer of the casualties from the landing beach or landing zone to the landing craft or helicopter.

Medical Battalion of the Marine Division

The Medical Battalion is comprised of five companies: a Headquarters and Service Company, and four Collecting and Clearing Companies.

The Headquarters and Service Company is composed of administrative, supply, and motor transport personnel. It also has a medical records section, a preventive medicine section, and two shock and surgical teams.

The Collecting and Clearing Company is composed of seven Medical officers, one Medical Service Corps (MSC) officer, 58 Hospital corpsmen, and 19 Marines. The company is divided into three platoons—one collecting and two clearing platoons.

The collecting platoon can be divided into three sections and has the function of evacuating casualties from the battalion aid station rearward either to the beach or to a clearing platoon.

The two clearing platoons, when combined, can establish a complete, but highly mobile, 60-bed (surgical facility) clearing station. In addition, each clearing platoon is capable of providing a separate 30-bed (surgical facility) clearing station to support units of less than a regimental-landing-team size or other widely separated units of an infantry regiment. The functions of these hospitals, whether a 30- or 60-bed facility, are to give resuscitation, lifesaving, and early definitive surgical care to casualties who are in immediate need and cannot withstand further evacuation.

Normally, one collecting and clearing company is assigned in direct support of a regimental landing team.

Medical and Dental Sections of Division Special Staff

The medical section of the division special staff consists of the Division Surgeon, one MSC officer, and five enlisted men. Among other duties, the division surgeon advises the commander on, and represents him in, all matters pertaining to the division medical service, supervises all medical activities within the division, including initiating and supervising execution of sanitary measures and recommending measures for control and prevention of disease, and ensures the keeping of all necessary records and reports.

The dental officer on the division special staff is also the commanding officer of the Force Dental Company which has been assigned to the division. As the division dental officer he supervises all dental activities within the division, advises the commander on all matters pertaining to dental service, prepares dental plans and orders, and ensures the keeping of necessary records and reports. He also coordinates with the medical officer of the command for temporary integration of dental personnel and equipment to assist in care, treatment, and evacuation of casualties in combat and disaster.

Medical and Dental Section of Force Special Staff

The Force Surgeon bears the same relation to the Force Commander as the Division Surgeon does to his Commander. In addition, when the Force Commander is the Amphibious Troops Commander, the Force Surgeon has the additional duty of coordinating the medical service of the Amphibious Force with that of the Amphibious Task Force, both in planning and during operations.

The Dental officer of the Force Special Staff bears the same relation to the Force Commander as the Division Dental officer to the Division Commander. And, in addition, he coordinates the Amphibious Force Dental Service when the Amphibious Task Force Commander is the Amphibious Troops Commander.

Force Hospital Companies

A Force Hospital Company is a separate Fleet Marine Force unit which may be attached to a force, division, or other task group. It is composed of seven medical officers, one MSC officer, 60 Hospital corpsmen, and 27 enlisted Marines. The mission of these companies is to provide resuscitation and primary definitive surgical facilities, including facilities for the establishment of a 100-bed hospital for the relatively minor wounded, sick and injured, and the evacuation of those casualties requiring prolonged hospitalization. Its secondary mission is to augment division medical facilities either as a complete unit or through the employment of provisional detachments organized within the company.

Separate Surgical Companies

A Separate Surgical Company is a Fleet Marine Force unit which may be attached to a force for operations. One of these companies is composed of 21 Medical officers, two Dental officers, three MSC officers, two Chaplains, 148 Hospital corpsmen, four Dental technicians, two Marine Corps officers, and 82 enlisted Marines. Their mission is to provide highly specialized surgical facilities within a Fleet Marine Force. In the early stages of an amphibious operation, the company may be organized into six teams for duty on casualty receiving ships. When the tactical situation permits, the company is established ashore as a separate entity, but not as a normal echelon in the chain of evacuation. It has facilities for the establishment of a 400-bed, semimobile hospital equipped to handle casualties requiring special surgery. All casualties requiring such surgery are routed to it from medical companies. Upon discharge, casualties are returned to their units, or are entered in the normal chain of evacuation.

Augmentation of the Marine Divisions, Wing Teams and Amphibious Forces

Under peacetime conditions, it would be a waste of critical medical manpower to staff all units of the operating forces to the levels required for combat. Line commanders fully appreciate this and have accepted a reduction in the number of medical personnel assigned them. This plan permits medical officers to be assigned

to the Shore Establishment where they can practice their specialties and maintain their professional competence. The cooperation of the line commanders is based on the premise that the Shore Establishment will immediately respond and provide them with the number and caliber of medical officers they require whenever the need arises.

In order to insure this responsiveness, the Bureau of Medicine and Surgery has developed an augmentation plan which is spelled out in BUMED Instruction series 6440.1 and 6440.2. These instructions may be found in the Appendix of this Guide.

This plan provides for the augmentation of two Marine Division/Wing Teams and the Amphibious Forces required to transport and support them. For any operation requiring more than these tactical units, the active strength of the Medical Department of the U. S. Navy would have to be increased.

The plan is based on the utilization of three groups of medical officers and corpsmen. *The First Group* consists of 20 surgical teams so constituted and equipped as to provide a surgical capability to any existing medical facility. These teams provide support for the amphibious force on ships designated as casualty receiving ships. They also may be used to increase the surgical capability of the medical battalion of a Marine Division. *The Second Group* consists of 12 Casualty Evacuation Teams for use in the Amphibious Force on ships designated as casualty evacuation ships. *The Third Group* consists of specialists designated by name who will be ordered to the Medical Battalion of a marine division to provide the division with the specialist capability it requires in combat.

To understand why augmentation of these forces is necessary, a knowledge of peacetime, as opposed to combat, staffing is essential. A marine division rates 73 medical officers (See Figure 2), but in peacetime it has a medical staff of about 38 medical officers which includes a division surgeon, a medical battalion commander, and an average of 38 general practitioners. A review of Figure 2 reveals that 35 specialists are required to bring the division up to its full medical strength.

A Marine Air Wing rates 40 medical officers on an average, for the composition of a wing varies with its mission. The following figure shows the assignment of medical officers to an average wing. There are no specialists assigned to a wing in peacetime. Therefore, to make a wing combat ready, 8 specialists are required.

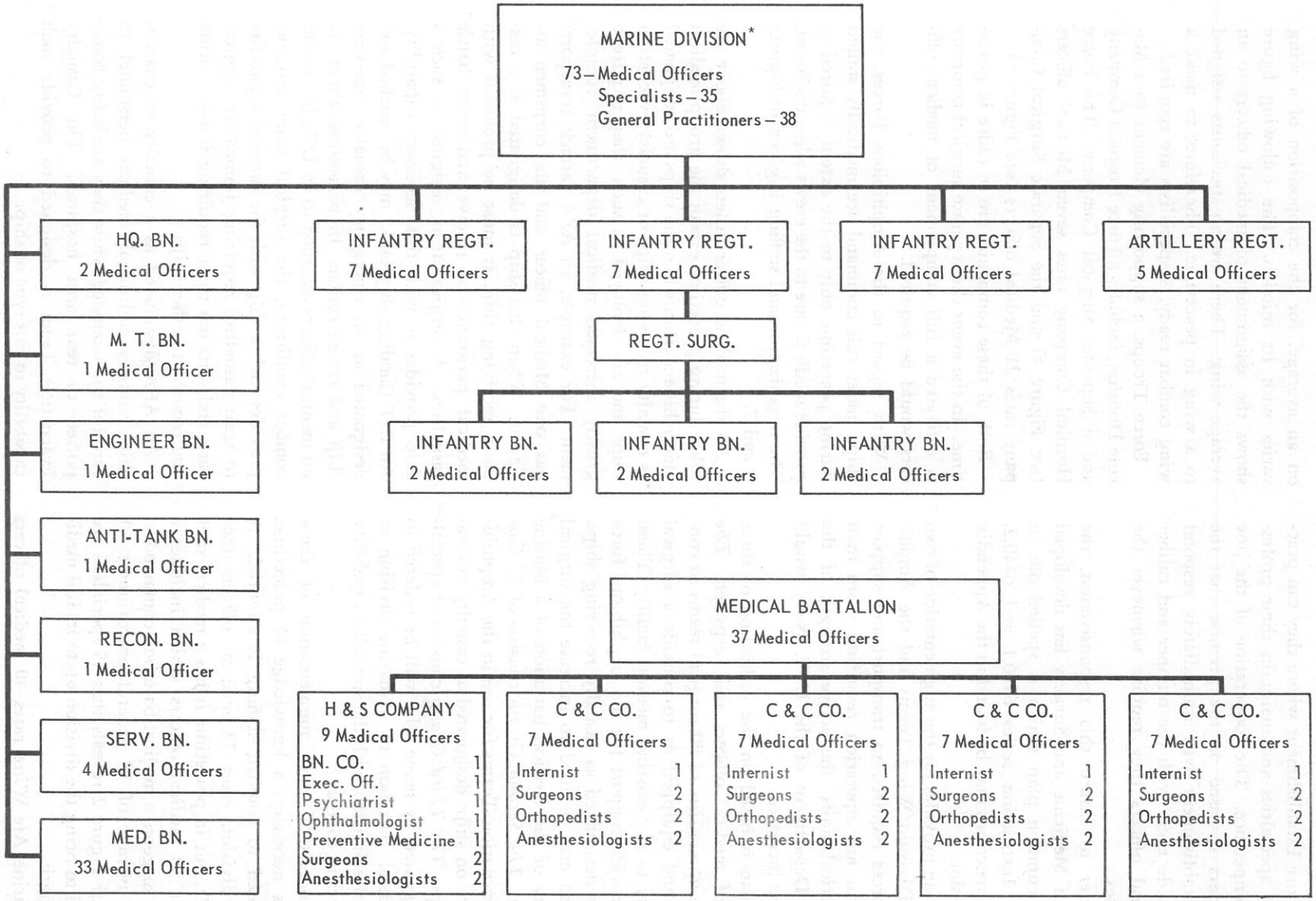
Force Troops, a supporting element to a Marine Division, includes a Force Hospital Company and a Separate Surgical Company. The Force Hospital Company rates seven Medical officers (see Figure 4) and the Separate Surgical Company rates 21 Medical officers (see Figure 5).

Both of these companies are in cadre in peacetime. In the event the separate surgical company is activated a full complement of medical officers would be required.

With regard to the Amphibious Forces, the ships under this command are medically staffed during peacetime only to the extent required to provide medical care to the crews when deployed. The organization and staffing is given in Figures 6 and 7.

All the medical officer billets shown above are filled during peacetime except the group medical officer billets. But, when the ships are designated as casualty receiving ships or casualty evacuation ships and are deployed as such, they require a greatly increased medical department complement. For example, an APA (attack transport) has one Medical officer and six corpsmen assigned. When this ship is designated as a casualty receiving ship, it must be provided with medical personnel to receive and treat battle casualties. A surgical team assigned to such a ship provides it with this necessary capability. An LST (landing ship tank) may be beached and designated as an emergency casualty receiving ship and triage center. In peacetime, there are no medical officers assigned to an LST, but under combat conditions, the surgical team assigned provides such a ship with the surgical capability to treat casualties requiring immediate surgical care, and sorts out those requiring transportation and removal to other ships.

An APA designated as a casualty evacuation ship requires additional medical personnel to care for the wounded while they are being transported to rear area hospitals. The Casualty Evacuation Team is designed to provide such capability to this type of ship.



*This table does not include the 4 Medical Officers and 18 Corpsmen with the 2 Shock and Surgical Teams, which are still considered a component of the Marine Division.

Figure 2 – Current Table of Organization of a Marine Division and a Medical Battalion

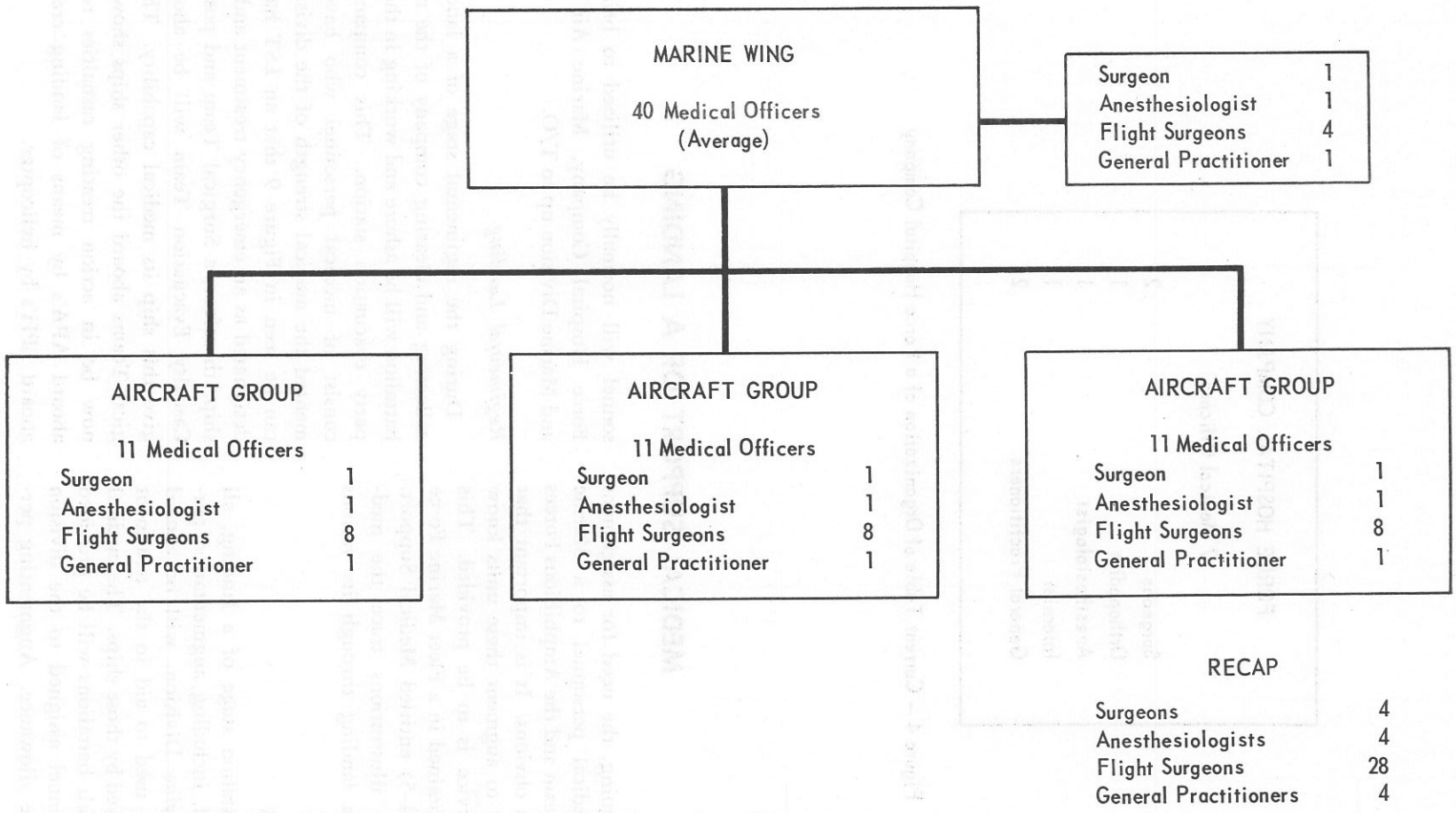


Figure 3 – Current Table of Organization of a Marine Wing

FORCE HOSPITAL COMPANY	
7 Medical Officers	
Surgeons	2
Orthopedist	1
Anesthesiologist	1
Internist	1
General Practitioners	2

Figure 4 – Current Table of Organization of a Force Hospital Company

MEDICAL SUPPORT OF A LANDING

From the foregoing, the need for assignment of additional medical personnel to a Marine Division/Wing Team and the Amphibious Forces that support it is obvious. It is important that the men assigned to augment these units know what medical service is to be provided. This information is contained in a Fleet Marine Force Manual (FMFM 4–5) entitled Medical Support.

The following illustrations trace the medical support of a landing through its various stages.

Battalion Landing

During the battalion stage of a landing, all medical personnel, including augmentation personnel for a Marine Division, will be aboard ship and may be used to aid in the treatment of casualties received by those ships. The medical personnel of assault battalions will be provided by medical personnel assigned to the division as their peacetime allowance. Augmenting personnel will normally be utilized to bring the Force Hospital Company, Marine Air Wing and Marine Division up to T/O.

Regimental Landing

During the regimental stage of a landing, a collecting and clearing company of the medical battalion will be ashore and working in the shore party evacuation station. This company will consist of medical personnel who have augmented the medical strength of the division. It can be seen in Figure 9 that an LST has been designated as an emergency treatment and triage ship; therefore, a Surgical Team and possibly a Casualty Evacuation Team will be aboard to give this ship its medical capability. The Surgical Teams aboard the other ships shown will now be in action treating casualties received aboard APA's by means of landing craft and aboard LPH's by helicopter.

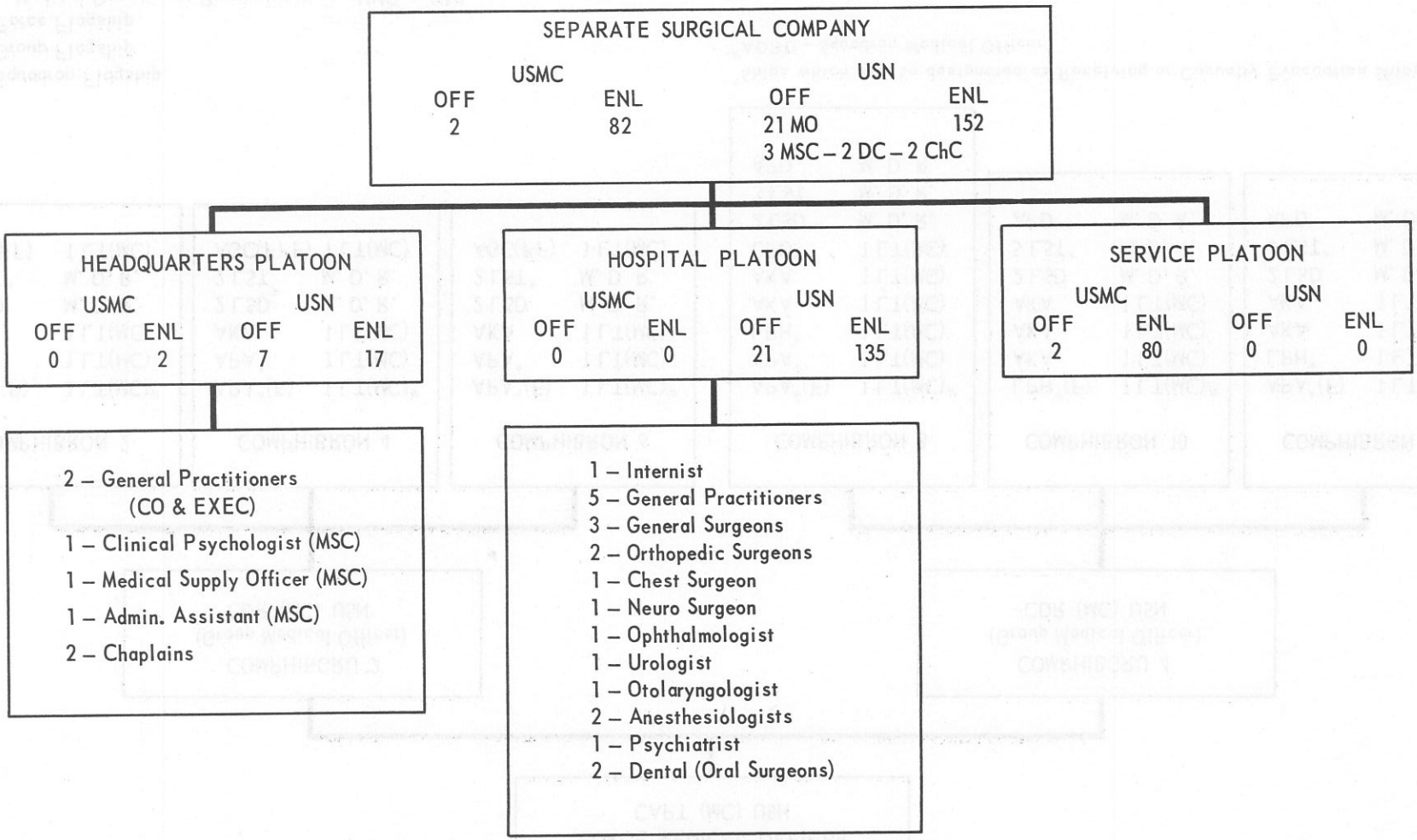
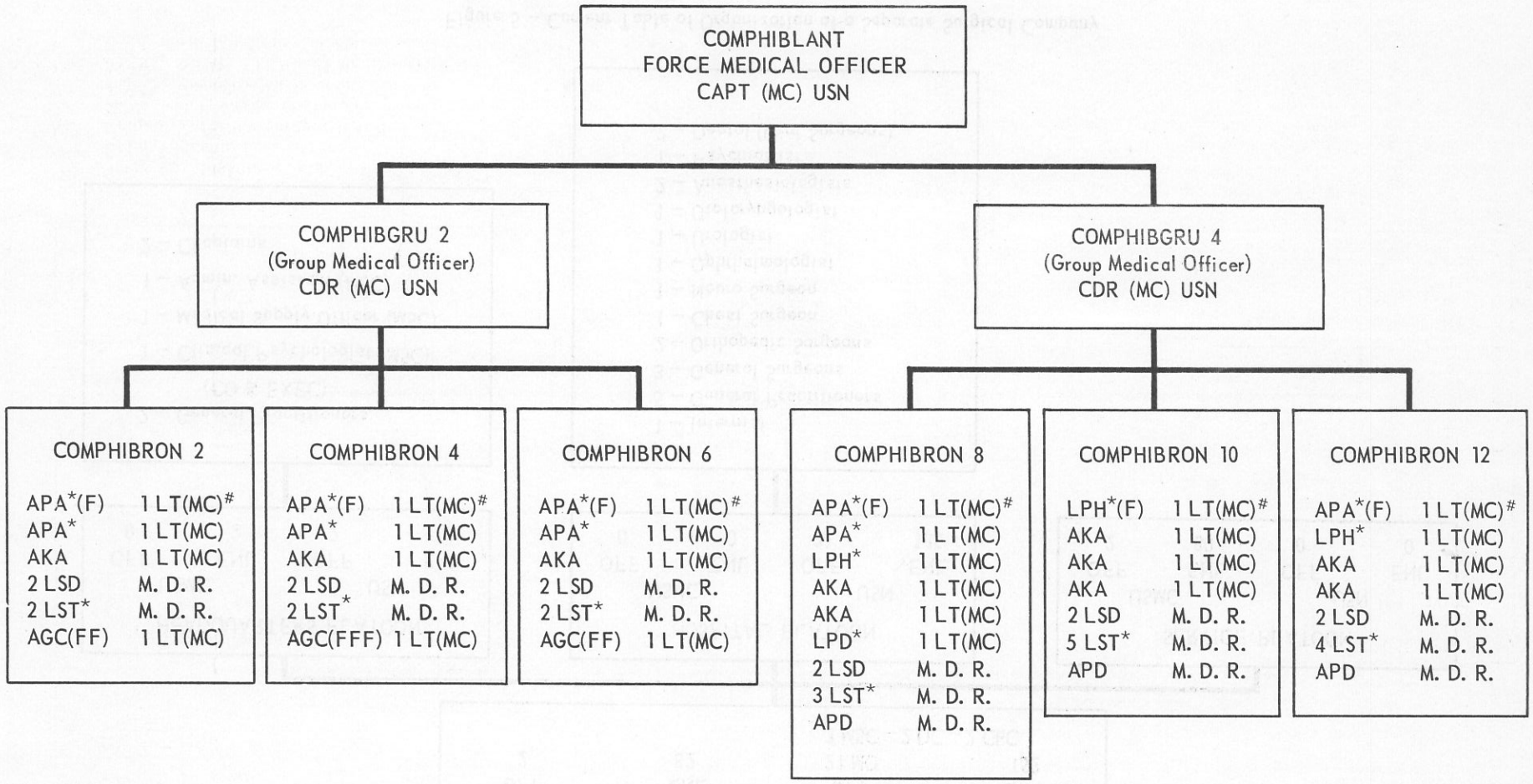


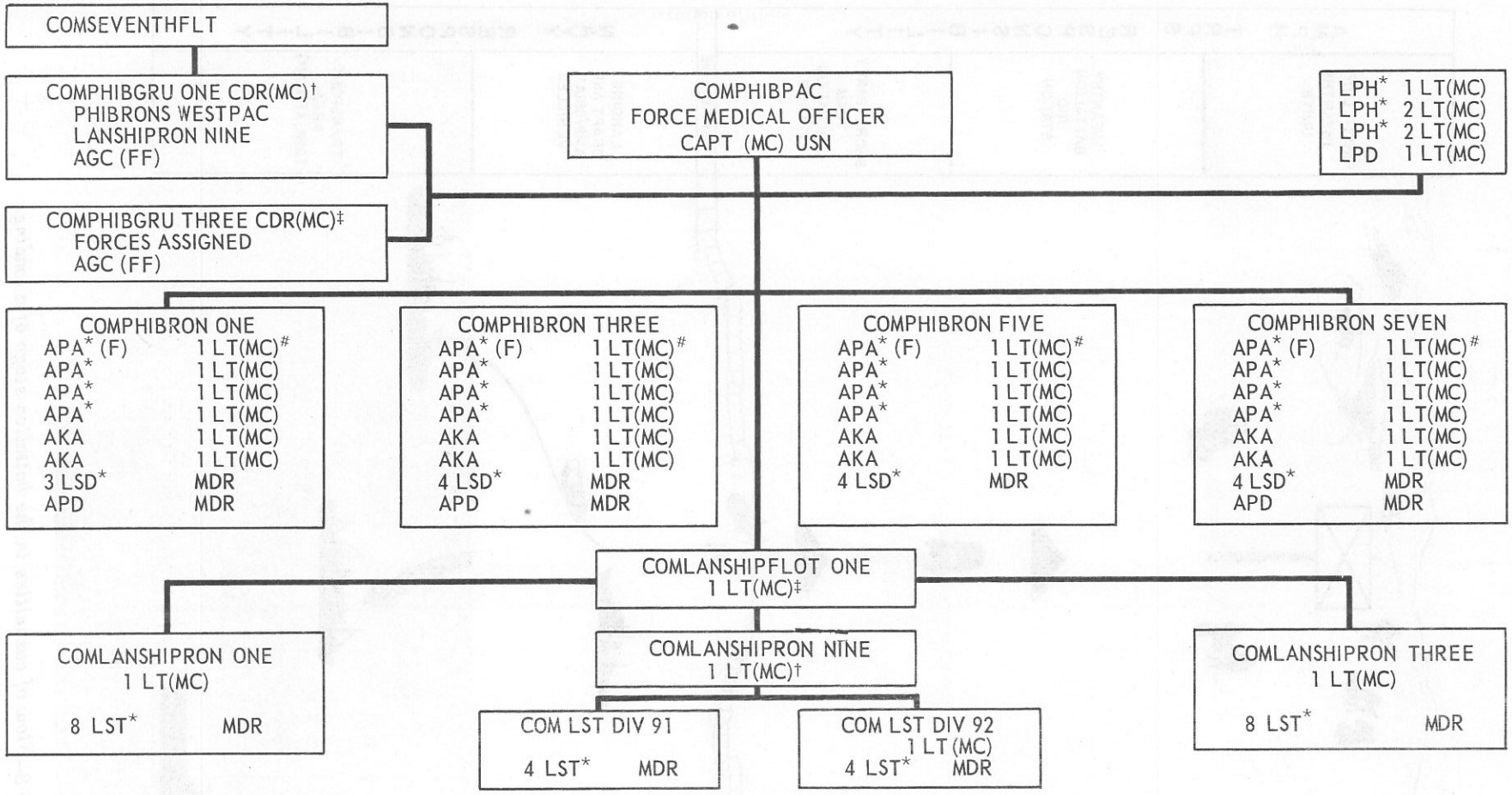
Figure 5 – Current Table of Organization of a Separate Surgical Company



(F) Squadron Flagship
(FF) Group Flagship
(FFF) Force Flagship
M. D. R. Medical Department Representative – HMC or HMI

*Ships which may be designated as Receiving or Casualty Evacuation Ships
#ADDU – Squadron Medical Officer

Figure 6 – Current Table of Organization of the Ships of the Amphibious Force, Atlantic



(F) Squadron Flagship
(FF) Group Flagship
MDR Medical Department Representative – HMC or HMI
* Ships which may be designated as receiving or casualty evacuation ships
\# ADDU – Squadron Medical Officer
† ADDU – COM LST DIV 91 Medical Officer
‡ Billet not filled during peacetime

Figure 7 – Table of Organization of the Ships of the Amphibious Force, Pacific

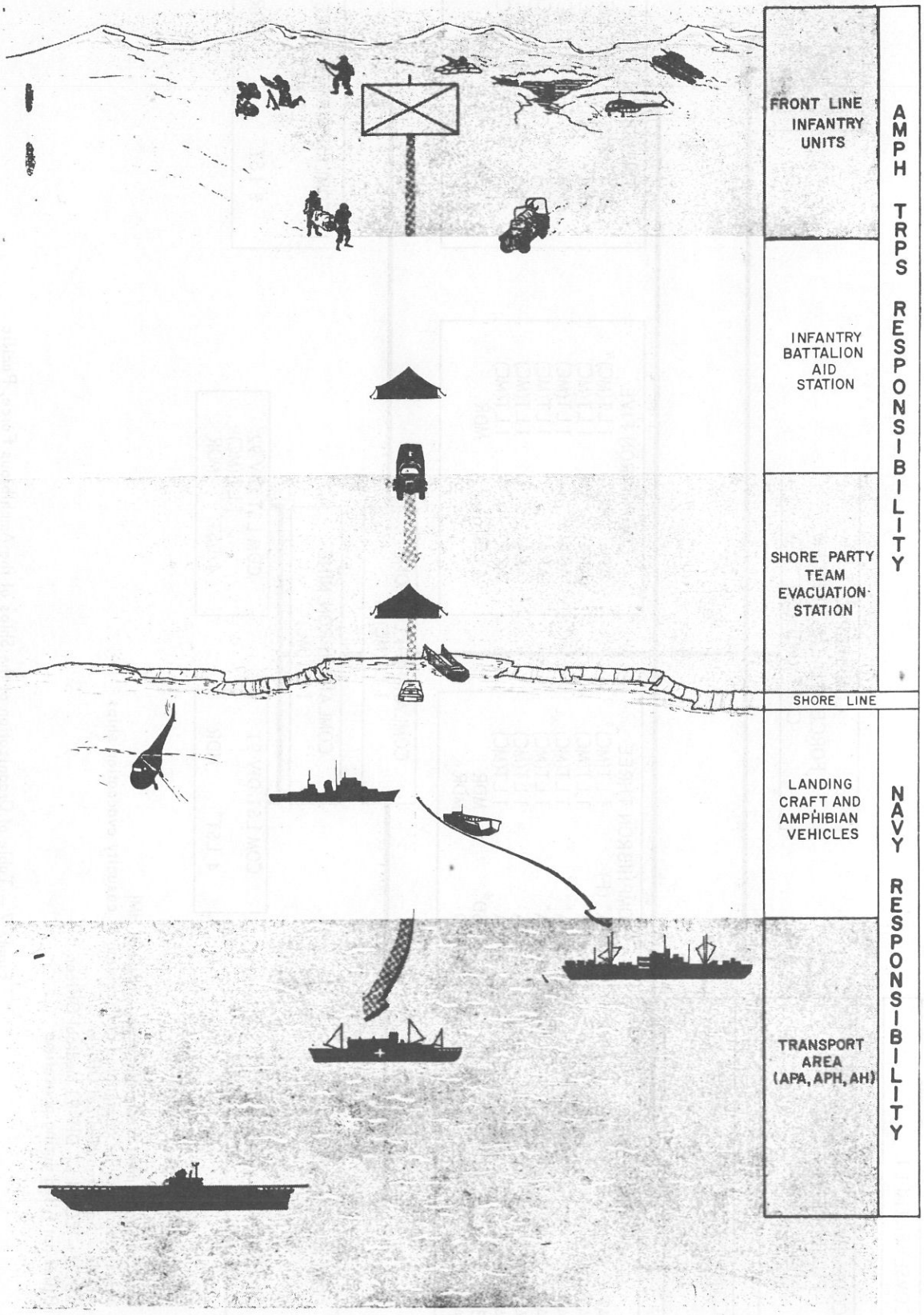


Figure 8—Flow of casualties in the battalion stage of a landing.

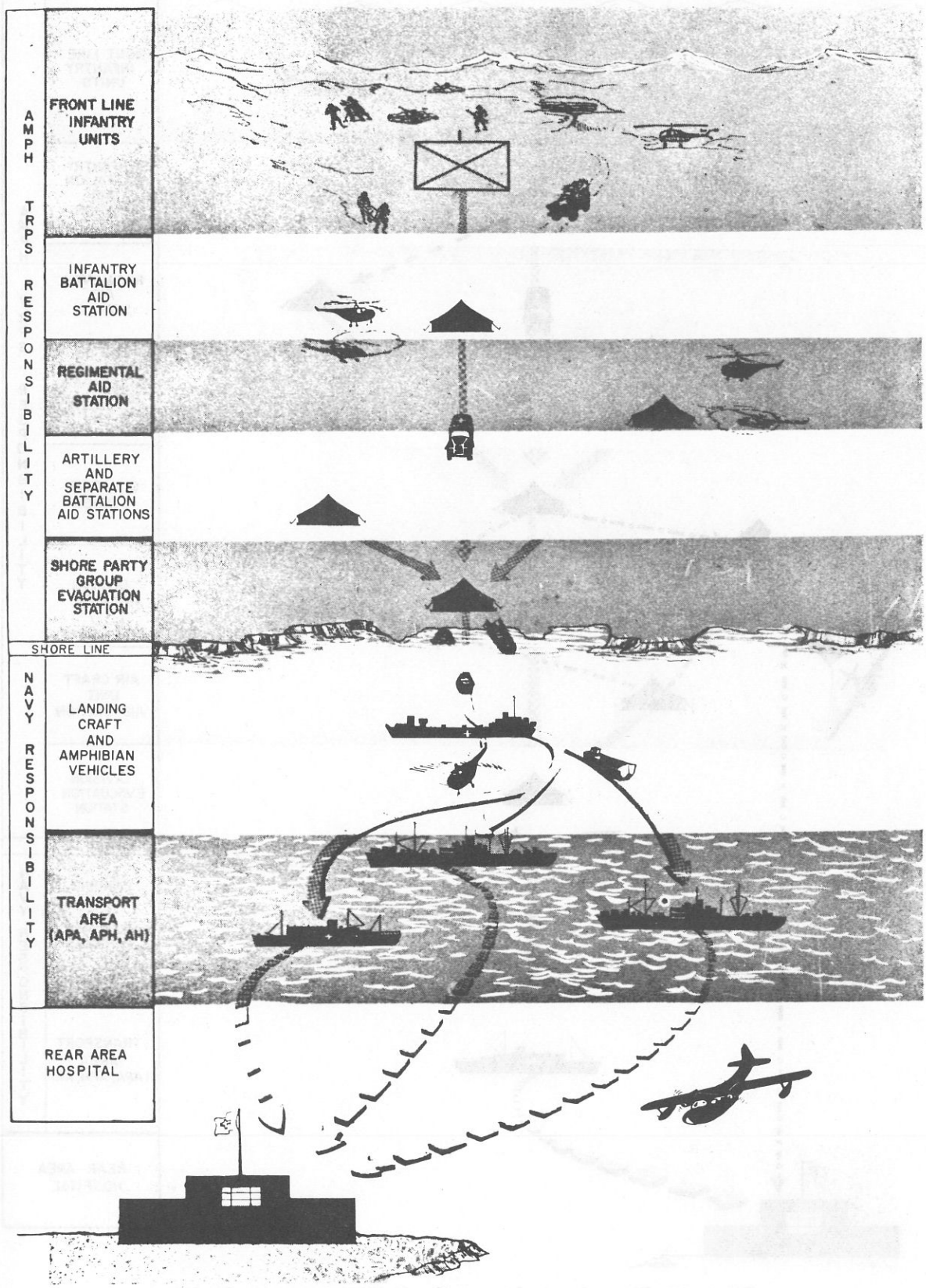


Figure 9—Flow of casualties during the regimental stage of a landing.

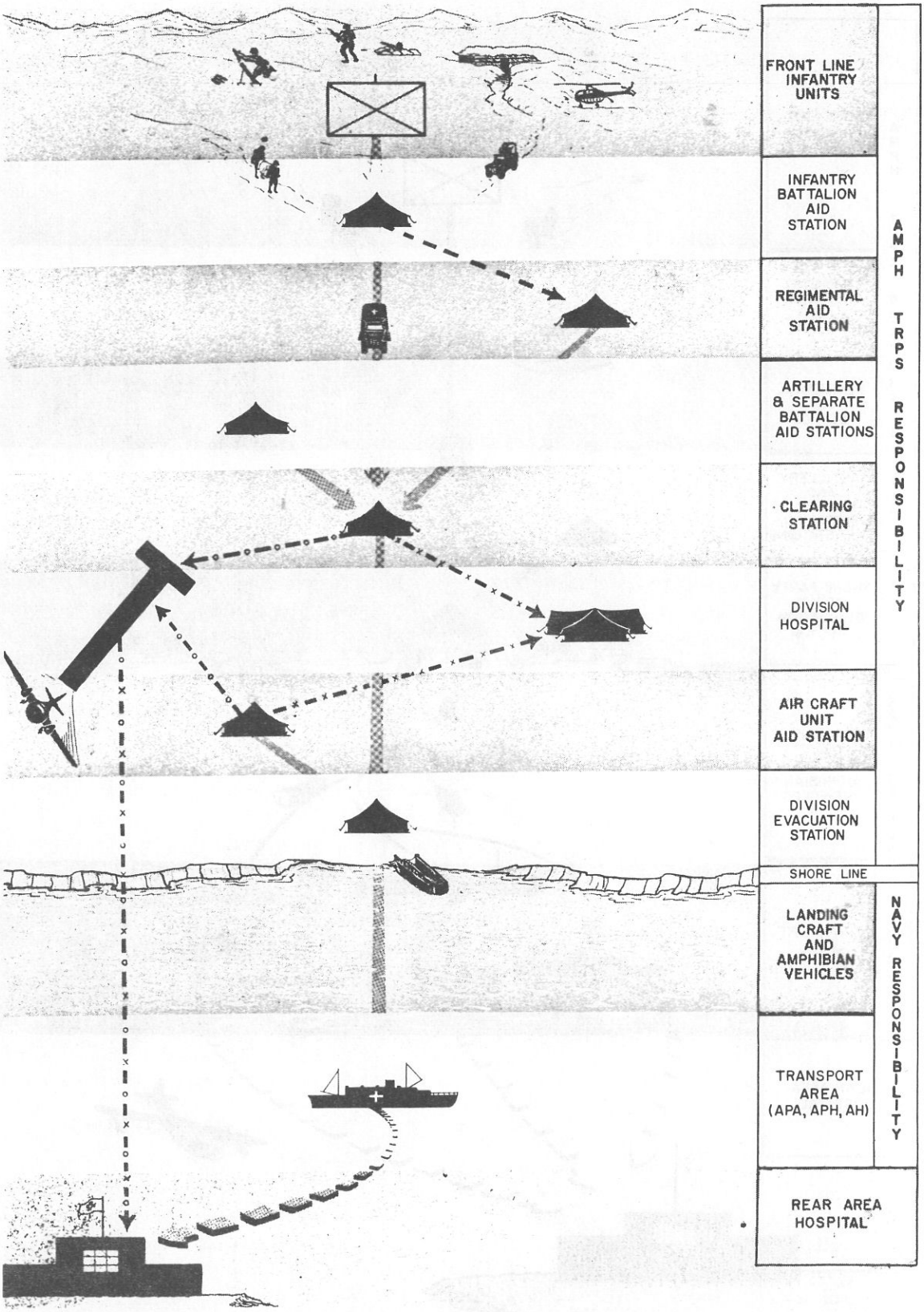


Figure 10–Flow of casualties in the division stage of a landing.

Division Landing

During the division stage of a landing, the medical battalion will have landed and personnel augmented to the division, working in the collecting and clearing companies, will be manning the areas shown in Figure 10 labeled clearing station, division hospital, and division evacuation station. Ships will still be receiving casualties, and surgical teams will still be aboard caring for them. Casualty Evacuation Teams may have already left the area on ships transporting casualties back to rear area hospitals. If the beachhead is secure enough, Surgical Teams which were working aboard ships may be moved ashore and add increased surgical capability to the clearing station, division hospital, or division evacuation station.

FLEXIBILITY OF MEDICAL SUPPORT

In the medical suport of any landing there must be fluidity. If the fighting prevents the landing of the collecting and clearing companies and the utilization of their clearing stations, then their personnel will help aboard ship. When the beachhead is secure enough and the companies have landed, then the treatment of casualties may be divided between the clearing stations ashore manned by medical companies and the ships manned by surgical teams. When the troops have moved inland from the beachhead and there is sufficient depth behind them, then the majority of casualties can be treated ashore and the surgical teams that were aboard ship can be sent ashore to join the medical companies. During this phase of the operation casualty evacuation teams will be utilized to care for casualties being evacuated to rear area hospitals.

There may be an ebb and flow of this pattern depending on the success of the landing. Reversal of forward progress may throw the major medical support from ashore back to ships. Speedy advance may bring medical support off ships before treatment of casualties aboard ship is necessary.

It is vital to the successful treatment of casualties that all medical personnel understand their role, in whatever unit they may be assigned, and the role of that unit in the entire concept of a landing. Medical personnel also, must be ready to accept the radical change in environment in which it may be necessary to perform their medical skills. From the white-tiled walls of the operating room of a naval hospital to the steel bulkheads of a ship or olive canvas of a field tent is a trip which requires adaptability and understanding acceptance. The medical mission can be fulfilled only if each individual can accommodate and accept the constantly changing pattern of an amphibious landing.

AUGMENTATION PLAN

Medical Support for the Marine Corps, as well as for the Fleet, has always been the responsibility of the Navy Medical Corps. When the Marine Units and the Amphibious Forces are not actively employed in a combat situation, it is unnecessary to staff these forces with the same number of medical personnel as would be required under combat conditions. Therefore, medical personnel working in the Shore Establishment are designated to augment the Operating Forces when they are ordered into combat readiness.

The "Augmentation Plan" is based on the utilization of three categories of medical personnel which augment a Marine division/wing team and the amphibious force that transports and supports it:

1. The Surgical Teams
2. The Casualty Evacuation Teams that augment the amphibious forces.
3. The Augmentation Personnel that fill the needs of the Marine divisions and wings.

I. SURGICAL TEAMS

A. Purpose

1. The first category consists of twenty (20) surgical teams so constituted and equipped as to provide a surgical capability in the medical support of amphibious operations of the Navy and Marine Corps. Also, to provide this same

support in national emergencies, disasters, or any situation which requires rapid movement of men and material to provide surgical capability. The Navy Medical Department has recognized this important requirement in its area of responsibility by the formation of these mobile teams of highly skilled medical officers and hospital corpsmen for assignment to existing medical facilities afloat or with the Fleet Marine Force.

2. The creation of Surgical and Casualty Evacuation Teams, and augmentation of personnel for the Fleet Marine Force, is part of the concept for providing the operating forces with the best possible medical coverage consonant with austerity of medical personnel in the Navy. By having these personnel promptly available, the operating forces are able to conduct normal peacetime activities with a minimum of medical personnel, knowing that in time of sudden need medical augmentation can be accomplished within a matter of hours. This plan is an economizing one, in that it permits us to utilize highly trained medical personnel at our busy hospital centers.

3. The geographic location of the various teams favors their assignment to duty with the nearest operating forces, or to disasters occurring in their locality, but allows assignment to either coast or to overseas areas on very short notice.

B. Composition

1. In consideration of its mission, each surgical team consists of three Medical officers (one General Surgeon, one Orthopedic Surgeon, and one Anesthesiologist) and 10 Hospital corpsmen (six operating room technicians, two of which may hold their operating room specialty as a secondary specialty rating, one laboratory technician, one field medical service technician, and two general service hospital corpsmen).

2. The Commanding Officer of the naval hospital sponsoring the team is responsible for the selection of its members. Their selection is to be based on individual specialty capability and merit, as vacancies occur.

3. The senior member of the team carries additional responsibilities as officer-in-charge and should, if at all possible, have experience in amphibious medicine. The senior hospital corpsman should be a HMC or HMI, preferably with medical field service training or experience.

4. Rotation of personnel assigned to a surgical team may be necessary since teams may be on 24 hour alert for prolonged periods. Commanding officers of naval hospitals sponsoring teams must insure that any rotation of personnel is staggered to maintain continuity of organization and to preclude deploying an untrained unit. Alternates must be designated, trained and made ready for deployment by being properly immunized, and otherwise prepared to allow for substitution in the event of reassignment, illness, or leave.

C. Mission and Duties

1. The primary mission of the Surgical Team is:

a. To function as a unit and to be employed as a unit. To furnish all the manpower and supplies necessary to provide one additional operating room anywhere ashore or afloat. To maintain mobility of its men and materials so that they can be moved rapidly from place to place as the situation dictates.

b. To furnish definitive surgical and post-operative care of hospitalized casualties in an amphibious objective, combat, or disaster area by augmenting the medical department personnel of the operating unit to which assigned.

c. To provide leadership, experience, and assistance in casualty handling and evacuation. Where Casualty Evacuation Teams are also assigned, the Officer-in-Charge of the Surgical Team will coordinate the work program of his team with the Officer-in-Charge of the Casualty Evacuation Team.

2. When deployed with the Amphibious Forces, Surgical Teams will be under the military command of the Operating Fleet Commander. The military chain of command passes down from the Fleet Commander to the Force or Type Commander, Squadron Commander, Unit Commander, and finally to the individual Ship's Commanding Officer. The Surgical Team is directly responsible to him. The Commanding Officer may assign such additional medical duties and responsibilities as he may be called on or choose to provide, e.g. medical guard or duty watches, provided they do not interfere with

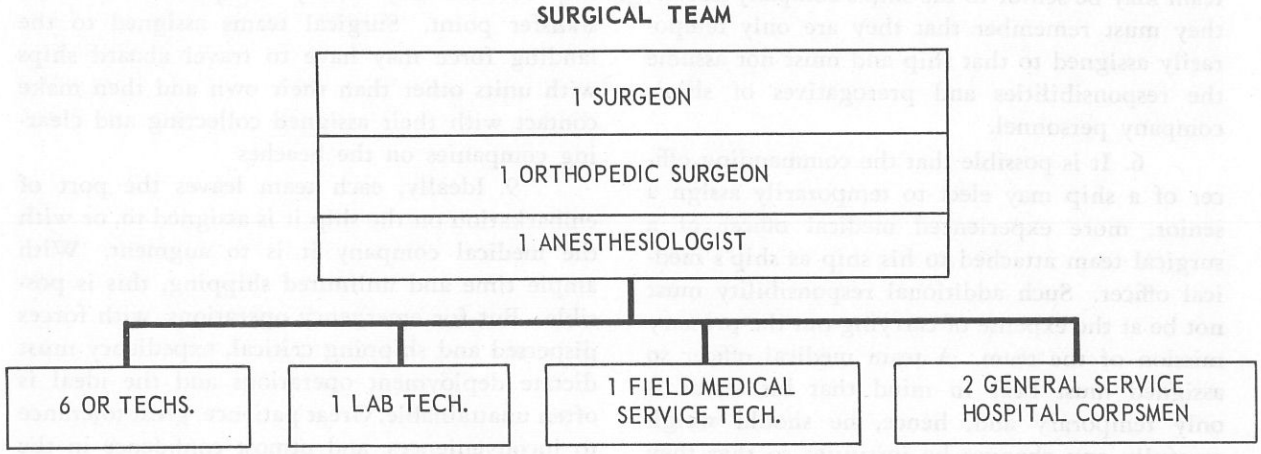


Figure 11 – Current Table of Organization of a Surgical Team

the primary mission of the teams. Surgical Teams which are designated to support the Landing Force are considered to be a detachment within the Landing Force Group.

3. There will be staff medical officers assigned to the force and group staffs. Any problems incident to the administrative and logistic support of the deployed surgical team should be promptly reported by message to the force and group commanders for action by the force and group medical officers. Required reports and significant needs should be submitted to the Amphibious Force Commander (Attn: The Force Medical Officer). It is of primary importance that all medical personnel conduct all official business through the commanding officer of the ship to which they are assigned. Action should not be initiated outside these channels for experience has shown this usually results in improper action or no action on the problem at hand. However, security requirements, communication overload, and force dispersal, preclude unlimited communication or personal contact between these staff officers and surgical teams. It must always be remembered that there are a number of competent, knowledgeable people working at higher echelons who are keenly interested in the functioning of the unit and are overseeing its movements and support.

4. Surgical Teams have been constituted, supplied, and equipped to join and operate with an already existent medical facility, either aboard an amphibious ship or with a Marine Corps Field Medical Unit. In a major deployment of teams, the greater majority will serve afloat with the amphibious ships to provide medical and surgical care in the seaward evacuation of casualties. A few will be predesignated and specially equipped for movement ashore to work in Marine Corps Field Hospitals.

5. Surgical teams employed on amphibious ships can expect assignment to designated casualty evacuation control ships (LST) or to designated casualty receiving ships (APA, LPH, LPD). Some of these ships will have a medical officer permanently assigned. The commanding officer of the ship is responsible for the successfull administration and operation of the medical

department of his ship. He delegates authority to his medical officer to accomplish this mission. Even though medical officers on the surgical team may be senior to the ship's company doctor, they must remember that they are only temporarily assigned to that ship and must not assume the responsibilities and prerogatives of ship's company personnel.

6. It is possible that the commanding officer of a ship may elect to temporarily assign a senior, more experienced medical officer of a surgical team attached to his ship as ship's medical officer. Such additional responsibility must not be at the expense of carrying out the primary mission of the team. A team medical officer so assigned must bear in mind that his status is only temporary and, hence, he should weigh carefully any changes he institutes so that they will not unnecessarily jeopardize the future position and program of the junior, but regular, ship's medical officer. Such a situation calls for the utmost in diplomacy and discretion on the part of the members of the surgical team, ship's medical officer, and corpsmen alike.

7. When the surgical team is assigned to a Marine Corps field medical unit, it will be under the military command of the landing force commander. The military chain of command passes down from the landing force commander to the Marine division commander to unit commanders. A surgical team will be assigned to the medical battalion for further assignment to a collecting and clearing company and be directly under the command of the commanding officer of that company. Any problems incident to the administrative and logistic support of the deployed surgical team should be promptly reported through the commanding officer of the collecting and clearing company to the commanding officer of the medical battalion attached to the division.

8. Specific assignments for surgical teams may not be possible in advance of a major assault. Initial assignments will be made by the Bureau of Medicine and Surgery to meet the requirements of the operating force. Surgical teams may be ordered to a specific ship, to the Commander, Amphibious Forces, or a Marine Division. Final assignments will be made by unit commanders. Surgical teams assigned to amphibious ships may have to wait to board the ship to which they are assigned until after they have left the port of embarkation. The first ship boarded may merely transport them to the transfer point. Surgical teams assigned to the landing force may have to travel aboard ships with units other than their own and then make contact with their assigned collecting and clearing companies on the beaches.

9. Ideally, each team leaves the port of embarkation on the ship it is assigned to, or with the medical company it is to augment. With ample time and unlimited shipping, this is possible. But for emergency operations, with forces dispersed and shipping critical, expediency must dictate deployment operations and the ideal is often unattainable. Great patience, great tolerance to inconveniences, and utmost confidence in the ability of those directing a massive and complicated operation is required to prevent morale from lowering. Compromising the situation even more is the inability to communicate with force and group medical officers or division or medical battalion surgeons who know the answers. It is at this juncture that intimate knowledge of the concept of the entire operation is essential, and this must be accompanied by complete reliance on those in command.

D. Training

1. Commanding officers of naval hospitals sponsoring surgical teams are charged with the responsibility of training the personnel assigned to the teams and should insure that they are provided with field training at the amphibious bases of the Navy at Little Creek or San Diego, and at the bases of the Marine Corps at Camp Lejeune or Camp Pendleton, as appropriate. Scheduling should be arranged by the commanding officer of the hospital sponsoring the surgical team (except Yokosuka) with the commander of the nearest amphibious base and the commanding general of the nearest Marine division. Details regarding transportation and training are contained in BUMED Instruction 6440.1C which is attached in the Appendix of this Guide.

2. Upon completion of periods of field training, the Senior Member of the Surgical Team will submit a written report to the Bureau of Medicine and Surgery outlining the phases of field training covered during the exercise. In

addition, any recommendations which will benefit other surgical teams in future field training exercises are to be included.

3. Training should be carried out at the local level through lectures, audio-visual aids, books, and films. In addition, surgical teams having surgical blocks in their possession are instructed to familiarize themselves with the contents. These blocks are to be opened, checked, and immediately re-packed to maintain the readiness posture of the team. Teams not having the blocks in their possession can derive similar experience during periods of field training at Camp Lejeune or Camp Pendleton by utilization of the surgical blocks assigned to the commanding generals.

4. Since the responsibility for training the surgical teams has been delegated to the commanding officers of the naval hospitals sponsoring the teams, it is required that they submit an annual report to the Chief, Bureau of Medicine and Surgery not later than 31 December. This report will cover all phases of training the team participated in during the calendar year.

E. Equipment and Supplies

1. The material required for outfitting surgical teams is designed to augment the medical facility to which the surgical team is to be assigned. The initial outfitting kit is designated as a Medical Equipment Kit, Surgical Team Supply Block, FSNL 6545–754–0234. This block provides consumable and nonconsumable material to support the surgical team at an existing facility for approximately 10 days. Resupply material for the surgical team is known as a Medical Equipment Set, Surgical Team Resupply Block, FSNL 6545–754–0241. This resupply block provides consumable material to extend the capability of the surgical team by approximately 10 days. To attain maximum military medical readiness, flexibility, and accessibility the component parts of the Surgical Team Supply Blocks shall be functionally packed. To insure that the packing is functional, the authorized allowance list of material is marked to indicate the nature and purpose of the contents. More explicit details regarding Equipment and Supplies are contained in BuMed Instruction 6440.1C. A list of components of these blocks prepared by the Field Branch, Bureau of Medicine and Surgery, may be found in the Appendix to this Guide. These supply blocks consist of 45 boxes totalling about 5,000 pounds and occupy 206 cubic feet.

2. Supply Blocks—these are prepositioned with the surgical teams at the following U. S. Naval Hospitals: Philadelphia, Pennsylvania; Bethesda, Maryland; Great Lakes, Illinois; Oakland, California; Portsmouth, Virginia; and Yokosuka, Japan. They are to be deployed concurrently with the team to a particular ship or port of embarkation. The officer-in-charge of the team must insure that the block is ready for shipment. In those cases where the supply blocks are not prepositioned with the Surgical Teams, the officer-in-charge of the team is not responsible for requesting the block. Request for and delivery of these blocks will be accomplished by competent higher authority by the most expeditious means available. The deployment of the operating forces and available shipping space, wherever possible, will be taken into consideration and, consistent with communication priorities, these teams will be provided shipping data. If, after a reasonable period of time, the block has not arrived, the officer-in-charge should advise, via official channels, the next higher echelon (Attn: Medical Officer).

3. Upon receipt of the supply block aboard ship or in the field, the officer-in-charge of the surgical team should determine that the serialized units are complete in number, as outlined on the manifest which accompanies the block. In general, the individual case units or boxes should not be opened unless utilization is imminent or until it is known that the operation order is to be executed. However, it must be remembered that in instances where the block was not prepositioned with the team, a lead time of about one work day is required to de-grease instruments and to make up and autoclave functional surgical packs. Instruments which have been packed in cosmoline are first rinsed in any solvent, such as gasoline, kerosene, or ether. After the cosmoline has been removed from the instruments they should be washed in a hot soapy detergent and rinsed in hot water. If time permits, the instruments should be boiled in hot water before inserting them in instrument packs. The supply block is not considered expendable

and after the operation is over, must be returned to the supply system or repositioned with the team and restocked.

II. CASUALTY EVACUATION TEAMS

A. Purpose

1. Casualty Evacuation Teams exist to give general non-surgical augmentation to ship's company medical department personnel and surgical teams aboard ships of the fleet in the handling of casualties of war or disaster. Their work is intended to be primarily in triage, pre and post-operative care and caring for non-surgical casualties.

2. The creation of Surgical and Casualty Evacuation Teams, and Augmentation of Personnel for the Fleet Marine Force, is part of the concept for providing the Operating Forces with the best possible medical coverage consonant with austerity of medical personnel in the Navy. By having these personnel promptly available, the Operating Forces are able to conduct normal peacetime activities with a minimum of medical personnel, knowing that in time of sudden need medical augmentation can be accomplished within a matter of hours. This plan is an economizing one, in that it permits us to utilize highly trained medical personnel at our busy hospital centers.

3. The geographic location of the various teams favors their assignment to duty with the nearest Operating Forces, or to disasters occurring in their locality, but allows assignment to either coast or to overseas areas on very short notice.

B. Composition

1. Each team consists of one medical officer (general practitioner or specialist) and 10 General Service hospital corpsmen. The Medical-Officer-in-Charge, if at all possible, should have experience in amphibious medicine and should have leadership potential. The Senior Hospital Corpsman should be a HMC or HMI, preferably with medical field service training or experience.

C. Mission and Duties

1. The Casualty Evacuation Team exists for several reasons:

a. To supplement ship's company and its augmenting Surgical Team in performing triage of casualties and handling shock therapy and pre and post-operative care, as well as to handle non-surgical casualties. Unless otherwise directed by the ship's Commanding Officer, the Officer-in-Charge of the Surgical Team is responsible for coordinating the work programs of the Surgical and Casualty Evacuation Teams.

b. When the patients aboard a casualty receiving ship no longer require the definitive care of a Surgical Team, the latter may be removed and the Casualty Evacuation Team left aboard to augment ship's company in rendering medical care to casualties enroute to CONUS or other port of debarkation.

c. Utilization of Casualty Evacuation Teams is envisioned as being almost exclusively aboard ship (APA, LPH, LPD, LST). However, there is always a possibility they might be ordered to the scene of a disaster ashore.

d. Under most circumstances the Surgical and Casualty Evacuation Teams are deployed for duty with the Operating Forces in an emergency situation. Organization of the teams and assignment of individual responsibilities to its members must therefore be generally outlined prior to an emergency. Once the teams have arrived at their assigned duty station, attention to familiarization with local working conditions and anticipated work load is necessary. The following general points must be fully resolved at each local level before casualties are received, if the teams are to function with success and efficiency:

(1) Evacuation route for casualties must be determined.

(2) Triage area must be designated.

(3) Triage personnel must be selected.

(4) Shock treatment personnel must be selected.

(5) Plans must be evolved for classification of casualties, especially those requiring immediate surgical care.

(6) Arrangements must be made for post-operative management of surgically treated casualties.

(7) Casualty treatment records must be provided.

(8) Casualty reports required by the medical annex of the operation order must be arranged.

(9) Method of evacuation for treated casualties must be understood from operation plans or next higher echelon.

e. When deployed, Casualty Evacuation Teams are under the military command of the Operating Fleet Commander and responsible to the Commanding Officer or Unit Commander to whom assigned. The latter may assign such additional medical duties and responsibilities as he may be called on or choose to provide, e.g. medical guard or duty watches, provided they do not interfere with the primary mission of the teams.

D. Equipment and Supplies

1. Casualty evacuation teams have no supplies or equipment assigned to them. They use the medical gear of the ship to which they are assigned.

III. AUGMENTATION PERSONNEL (LESS SURGICAL TEAMS)

A. Purpose

1. This group of medical personnel, of varying specialties and skills, that augments the Marine Division/Wing Team is assigned to medical billets with Fleet Marine Force units to bring those units up to authorized combat strength. During peacetime these billets are left vacant so as to permit these highly trained specialists to work in the hospital centers. These medical officers will not know until reporting what specific billets they will fill. The Division Surgeon or Wing Surgeon will assign them in consonance with each individual's medical background, training, and experience. By seniority, a medical officer may find himself assigned as commanding officer of a collecting and clearing company. Others may be in charge of the medical personnel assigned to a medical unit of an air wing. It must be made absolutely clear at this point that medical personnel already assigned to a Marine division or a Marine air wing may be junior to augmenting personnel, but be in a position of authority over such personnel. It is inevitable, for example, that surgeons or internists ordered to the medical battalion of a Marine division will be senior to the medical battalion commanding officer. The medical personnel permanently assigned to these units being augmented are trained in their operation, are familiar with their equipment, and have worked with the line units they support. Augmenting personnel must respect their experience and training and defer to their authority despite a discrepancy in rank. This appears to be a small price to pay for being allowed to serve in the Shore Establishment and maintain clinical competence while their fellow officers are serving with the operational forces.

2. The creation of Surgical and Casualty Evacuation Teams, and augmentation of personnel for the Fleet Marine Force, is part of the concept for providing the operating forces with the best possible medical coverage consonant with austerity of medical personnel in the Navy. By having these personnel promptly available, the operating forces are able to conduct normal peacetime activities with a minimum of medical personnel, knowing that in time of sudden need medical augmentation can be accomplished within a matter of hours. This plan is an economizing one, in that it permits us to utilize highly trained medical personnel at our busy hospital centers.

3. The geographic location of the augmentation personnel favors their assignment to duty with the nearest operating forces, or to disasters occurring in their locality, but allows assignment to either coast or to overseas areas on very short notice.

B. Composition

1. Augmentation personnel are not organized in teams or units, but are individually selected from the naval hospitals for their specialty capability. They are selected to provide the specialty requirements as set forth in the current U. S. Marine Corps table of organizations and the estimated requirements of the amphibious forces. This augmentation group includes Medical Corps officers, Medical Service Corps officers, and Hospital corpsmen. The personnel plan for augmentation of medical units; Fleet

Marine Force and Amphibious Forces is contained in the BuMedInst 6440.2 series which appears in the Appendix of this Guide.

C. Training

1. Medical officers assigned as individuals to fill the vacant billets in the Marine Division Wing Team are designated by name by their commanding officers and the names sent forward to the Bureau of Medicine and Surgery. The Bureau encourages local indoctrination of such individuals, and it is hoped that this Guide will be helpful in supplementing this program. In addition, the Bureau orders as many of those designated as is consistent with the over-all needs of the Medical Department to the Field Medical Orientation Course given at Camp Pendleton and Camp Lejeune.

2. The keystone of the medical support to a division/wing team is the permanently assigned medical personnel. For example, there are Medical Service Corps officers and enlisted personnel who have been trained in the logistics and operation of a collecting and clearing company. Augmenting personnel should rely on them for guidance in the administrative functions of their units. It is only because there is such a nucleus of trained personnel already with the division/wing team that an augmentation plan is possible.

D. Equipment and Supplies

1. Personnel augmenting division/wing teams have no equipment or supplies assigned them. They use the medical gear of the unit to which they are assigned.

INDIVIDUAL RESPONSIBILITIES OF DEPLOYED PERSONNEL

Under most circumstances, medical personnel augmenting a division wing team and medical personnel constituting surgical and casualty evacuation teams are deployed for duty with the operating forces in an emergency situation. These medical personnel should understand their individual responsibilities prior to deployment.

Those designated for augmentation duty are expected to be expert in the management of casualties. Because of their supply blocks, surgical teams are uniquely capable of assisting in disaster areas and can expect to be used for such purpose. Medical personnel can be expected to be called upon in the event of chemical, biological, and radiological attack, or major accident. The references on page 26, 27 of this Guide will supply material which will help prepare medical personnel to handle such casualties.

Medical Personnel must bring to their assignment with the operating forces more than just mastery of the medical aspects of this job. They must also be vigorous of body and mind, knowledgeable in the ways of preserving their own lives under fire, and able to adjust to the rigors of life aboard a ship or in the field under combat conditions.

If they are to be able to withstand the grueling days and nights of a prolonged engagement, short rations, lack of sleep, exposure to the elements and living in constant danger, they must be physically fit. Physical stamina is also inherent to successful performance in the operating room of a ship or in the field hospital of a clearing station where long hours are not the exception but the rule.

One of the most important attributes required of medical personnel assigned to the operating forces is the ability to improvise. While the general pattern of medical department activities and the methods of caring for casualties remain essentially the same, every operation and every situation encountered therein has its problems that must be met and overcome. Environmental conditions and enemy interference all conspire to produce situations that demand initiative and aggressive action for their solutions.

There is little occasion for medical personnel busily engaged in clinical practice to be conscious of security with regard to classified information. However, awareness of the classification of information becomes vital with assignment to the operating forces. For any specific operation, the commander at each level of command promulgates "operational plans" which become

"operation orders" on execution. The medical support to any operation is usually outlined and prescribed in the medical annex to the administrative plan in the Fleet Marine Forces and the medical annex or medical appendix to the logistics annex of such operation orders in the amphibious forces. Most of the annexes or appendices carry a "Secret" security classification. Senior augmenting personnel who may be assigned as commanding officers of collecting and clearing companies and officers in charge of Surgical Teams must be cleared to receive information classified as "Secret" so that they can become cognizant of the medical plans for their respective companies or ships upon reporting. In addition, all hands must be exceedingly careful of the information they include in personal or unclassified official communications. Insignificant bits of information from several sources concerning places of embarkation, numbers, mission, et cetera, might well compromise an entire operation and cost many lives.

After reporting to their assigned station, attention to familiarization with local working conditions and anticipated workload is necessary. The following general points must be fully resolved at each local level before casualties are received, if the operation is to be sucessful:

1. Evacuation routes for casualties must be determined.
2. Triage areas must be designated.
3. Personnel must be selected and assigned to triage.
4. Personnel must be selected and assigned to the treatment of shock.
5. Preparations must be made for the pre- and post-operative management of surgical casualties.
6. Plans must be made to maintain casualty treatment records.
7. Arrangements must be planned to prepare casualty reports required by the medical annex of the administrative plan for the Fleet Marine Force and the medical annex or medical appendix to the logistics annex of such operation orders in the amphibious forces.
8. Methods of evacuation for treated casualties must be understood from operation plans or by briefings with the next higher echelon.

To furnish surgical teams, evacuation teams and augmentation personnel with estimates as to the types and numbers of battle casualties to anticipate, the S–3 (training) section of the 2nd Medical Battalion, 2nd Marine Division, FMF, Camp Lejeune, North Carolina, has prepared the pamphlet on "Battle Casualties" which is attached in the Appendices of this Guide.

PERSONAL AFFAIRS

In most situations, when the services of surgical and casualty evacuation teams or Fleet Marine Force augmentation personnel are contemplated, the members will be placed on an alert status by appropriate authority. This period of alert is usually short and will not allow enough time for many time-consuming details to be accomplished. Therefore, upon assignment to teams or augmentation groups, the command and the individual members should take action to be ready for sudden deployment. Among these actions are the following significant items which can easily be kept current once accomplished:

By The Command

(1) Health Record—must be verified and current in regard to all immunizations, including yellow fever, cholera and typhus. Immunization Card DD Form 737 should be held by each person. (See current BuMed Directive 6230 Series re: Immunization for sudden world-wide deployment, included in Appendices.)

(2) Dental Record—the Standard Form 103 should be up to date (valuable means of identification). (BuMed Man. 6–107–8.)

(3) Service Record—the Record of emergency data, NavPers 601–2 (New 4–61) should be up to date. (BuPers Man. B-2312.) (Sample form Included in Appendices.)

(4) Pay Record—make Certain all allotments registered to cover insurance, bonds, dependents, et cetera, are forwarded to Navy Finance Center.

(5) Identification Tags—(BuPers Man. B–2102.)

(6) Identification Card—DD Form 2N Active—make sure it is current. (BuPers Man. B–2103.)

(7) Geneva Convention I. D. Card—DD Form 528 (BuPers Man. B–2106.)

(8) Insure that the officer-in-charge of a surgical or casualty evacuation team and senior medical personnel designated for augmentation of the Fleet Marine Force have secret security clearances and that they are so certified in their orders when deployed.

By The Individual

(1) Check insurance policies and determine that beneficiaries are correctly designated.

(2) Make certain that allotments are registered to cover all financial obligations, BuPers Man. A–4101 (4), and to provide the family with money while away.

(3) Check with station legal officer relative to:

(a) A valid last will and testament, e.g., proper number of witness signatures according to requirements of various states, etc.

(b) Power-of-attorney.

(c) Joint bank account (with wife or nearest of kin.)

(d) Co-ownership on personal property, such as car, stocks, bonds, real estate, et cetera.

(e) Memo to next of kin regarding location of property or special instruments, such as insurance policies, safety boxes, tax receipts, deeds, et cetera.

(f) Any other personal legal problems.

(4) Assure that a ready supply of cash will be available. Delays in drawing pay under emergency situations are frequent.

Officers are required to purchase their own clothing and should procure them in advance. All officers should have Marine utility clothing in their possession.

1 pair of combat boots	@	$6.00
2 coats, utility	@	2.60 ea.
2 trousers, utility	@	2.80 ea.
2 pairs, woolen double-soled socks	@	.50 ea.
1 cap, utility	@	.50

This is the minimum recommended to be ready for immediate deployment. These items are available at any Marine Corps activity e.g., Marine Base, barracks, reserve units, et cetera, either in stock or by mail requisition. Extra items may be obtained during deployment. All officers and chief petty officers must have at least three sets of washable khaki uniforms (since duty with the operating forces often involves locations where dry cleaning facilities are not available). They will wear service dress blue or service dress khaki when traveling in execution of deployment orders, depending on the season of the year and the geographical locations of the units to which assigned.

Enlisted personnel must have a full sea bag. If they are assigned to duty with Marine Corps units, they will be furnished Marine Corps uniforms and field clothing as follows:

BAG, Duffel	1
BELT, Coat, Wool, Green	1
*BELT, Trousers, Web, Khaki	2
*BOOT, Combat, Pair	1
*BUCKLE, for Web Khaki belt	1
BUCKLE, for Wool Green Coat	1
CAP, Garrison, Green	1
CAP, Garrison, Khaki	1
CAP, Garrison, Tropical	1
*CAP, Utility	2
CLASP, Necktie, USMC	1
COAT, Green	1
COVER, Service Cap, Green	1
FRAME, Service Cap	1
*GLOVES, Leather, Pair	1
INSIGNIA, Black, Cap (Screw Post)	1
INSIGNIA, Black, Collar (Clutch Type) Rt.	2
INSIGNIA, Black, Collar (Clutch Type) Lt.	2
NECKTIE, Khaki	2
SCARF, Neckwear	1
SHIRT, Cotton, Khaki	2
*SHIRT, Olive Green (Utility)	3
SHIRT, Khaki, Tropical	1
SHOES, Service, Pair	1
SHOES, Dress, Pair	1
SOCKS, Brown, Pair	4
SOCKS, Black, Pair	4

* Only uniform articles required for field use.

TROUSERS, Green	1
TROUSERS, Khaki, Cotton	2
TROUSERS, Khaki, Tropical	1
*TROUSERS, Olive Green, Utility	3
*INSIGNIA, Grade, Metal	3

Both officers and enlisted personnel will be issued additional Marine Corps personal equipment called "782" gear which consists of the following:

BAND, Liner, Helmet, Head	1
BAND, Liner, Helmet, Neck	1
BELT, Pistol, Web	1
CAN, Meat with cover	1
CANTEEN	2
COVER, Canteen	2
CUP, Canteen	1
COVER, Helmet	1
FORK, Haversack	1
HELMET	1
KNAPSACK	1
KNIFE	1
LINER	1
PINS, Tent, Shelter Half	5
POLE, Tent, Shelter Half	1
PONCHO	1
SPOON, Haversack	1
SUSPENDER, Belt, Pair	2
TENT, Shelter Half	1
SHOVEL, Entrenching	1
STRAP, Blanket Roll	1
LINE, Guy	1
BLANKET, Wool, Green	1
JACKET, Field	1
LINER, Jacket Field	1
HOOD, Jacket Field	1
TENTAGE	1
AIR MATTRESS	1
SLEEPING BAG	1
UNDERWEAR, Winter	2

*Only uniform articles required for field use.

It is the responsibility of the Marine Corps to issue Marine Corps uniforms and field clothing to enlisted personnel and "782" gear to officers and enlisted personnel.

This situation holds particularly for contingency operations. A decision by the President of the United States is made to demand certain action from a foreign power. He cannot make this demand unless he is ready to back it up militarily. He therefore orders his military forces into position, ready for combat. This takes time. Then, he makes his demand and awaits the decision of the foreign power. This also takes time. And, all the while, medical personnel must be with the operating forces. No one has a specific time table for such a situation, not even the senior commanders of the operating forces. They cannot compromise their combat readiness under these circumstances by allowing medical personnel to continue working in their clinical assignments until the bullets actually start flying. And if the foreign power accedes to the President's demand, the bullets never fly.

Medical officers and hospital corpsmen must understand the indefinite character of contingency operations. They must accept the medical inactivity it generates without a loss of motivation and with the full satisfaction of having been ready to meet a need and be sincerely grateful that this need did not arise.

When ordered to a specific duty assignment with the operating forces, all medical personnel should carry their *pay records, health records, dental records,* and *service records.* Depending upon operating forces requirements, period of temporary additional duty may vary from several days to months in duration.

SUMMARY

This guide has been prepared to provide background information and specific recommendations to medical personnel liable for duty with the operating forces. Emphasis has been given to actions that will insure a readiness posture. It seems fitting to conclude this guide with a reference to a facet of a military operation which is best expressed by the cliches, "Prepare to Standby" or "Hurry Up and Wait." There is nothing more demanding of medical personnel than the inactivity intrinsic in an assignment to a combat unit which "might be at any time" but

is not actually engaged in combat. Yet, in order to have that unit poised for action, medical personnel must be aboard and prepared. This taxing experience is resolved when combat action commences, and the memory of it disappears with the stimulation derived from the professionally rewarding work of treating casualties and being identified as a member of the fighting team. But, when this stimulation is not forthcoming when the fighting does not occur, and when the memory of the medical inactivity is heightened by a return to a parent activity that was sorely taxed to provide medical care during the period of absence, then the reasons why augmentation duty was necessary become obscure to the uninitiated.

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CORRESPONDENCE COURSES

The following courses are available through the U. S. Naval Medical School, NNMC, Bethesda, Maryland:

NavPers 10701–A	Atomic Medicine
NavPers 1–706–A	Combat and Field Medicine Practice
NavPers 10772	Control of Communicable Diseases in Man
NavPers 10765	Treatment of Chemical Warfare Casualties
NavPers 10995	Tropical Medicine in the Field
NavPers 10705–A	Insect and Rodent Control

TRAINING FILMS

MEDICAL SUPPORT IN A MARINE AMPHIBIOUS ASSAULT: CONDUCT OF THE LANDING.

MOTION PICTURE

U. S. DEPARTMENT OF THE NAVY, 1963 MN–9513d)

MEDICAL SUPPORT IN A MARINE AMPHIBIOUS ASSAULT: THE GENERAL AND SPECIAL SITUATION.

MOTION PICTURE

U. S. DEPARTMENT OF THE NAVY, 1963 (MN–9513b)

MEDICAL SUPPORT IN A MARINE AMPHIBIOUS ASSAULT: THE MEDICAL PLAN.

MOTION PICTURE

U. S. DEPARTMENT OF THE NAVY, 1963 (MN–9513C)

MEDICAL SUPPORT IN A MARINE AMPHIBIOUS ASSAULT: ORGANIZATION OF A MARINE EXPEDITIONARY FORCE.

MOTION PICTURE

U. S. DEPARTMENT OF THE NAVY, 1963 (MN–9513a)

MILITARY SURGEON IN AMPHIBIOUS ASSAULT (MN–6910)

MEDICAL SUPPORT IN SHIP TO SHORE OPERATIONS (MN–4326)

MARINES AT TARAWA (MA–3527)

PERSONAL HYGIENE (MA–8944)

WITH THE MARINES FROM CHOSEN-HENGNAM (MN–7314)

MEDICAL SUPPORT FOR AMPHIBIOUS OPERATIONS 1963

MN 9513	A III
NM 9513	B III
MN 9513	C III
NM 9513	D III

APPENDICES

APPENDIX I

DEPARTMENT OF THE NAVY
Bureau of Medicine and Surgery
Washington 25, D.C.

BUMED 6440.2A
BUMED-317
15 October 1962

BUMED INSTRUCTION 6440.2A

From: Chief, Bureau of Medicine and Surgery
To: Distribution List

Subj: Augmentation of medical units, Fleet Marine and Amphibious Forces

Ref: (a) BUPERSINST 1321.2 series
(b) BUMEDINST 6440.1 series (NOTAL)

Encl: (1) Personnel Plan for Augmentation of Medical Units, Fleet Marine and Amphibious Forces

1. Purpose. To assign to naval hospitals and preventive medicine units the responsibility of augmenting medical units of the Fleet Marine and Amphibious Forces with certain medical officer specialists and/or evacuation teams.

2. Cancellation. BUMED Instruction 6440.2, Subj: Augmentation, medical units, Fleet Marine Force, is hereby canceled.

3. Background. The medical units of the Fleet Marine and Amphibious Forces are not staffed at combat strength. In the event of deployment, immediate augmentation is necessary to bring the number of medical officers up to complement and insure that the medical officers supplied meet the specialist requirements as set forth in the current U.S. Marine Corps Tables of Organizations and the estimated requirements of the Amphibious Forces.

4. Administration. In the event of deployment, TAD orders should be issued in accordance with instructions contained in reference (a). Personnel should be directed to report to the appropriate commander, as designated by BUMED, for TAD in connection with medical matters. The funds for per diem and transportation for deployment are chargeable to a BUMED controlled allotment. Appropriate accounting data will be furnished by BUMED. Travel by Government aircraft shall be directed when available. Class ONE priority shall be certified. Where no Government aircraft is available, travel by commercial air should be authorized where necessary to expedite reporting for duty.

5. Action. Each activity shall designate the number and types of medical officer specialists and hospital corpsmen for which they are responsible in accordance with the requirements contained in enclosure (1). The medical officers selected should be Regular medical officers whenever

PERSONNEL PLAN FOR AUGMENTATION OF MEDICAL UNITS,
FLEET MARINE AND AMPHIBIOUS FORCES

Specialists will be ordered to Fleet Marine and Amphibious Forces from the activities listed below, in the number indicated:

	Surgeons	Orthopedic surgeons	Anesthesiologists	Internists	Ophthalmologists	Psychiatrists	Evacuation Teams (See NOTE)
Annapolis							1
Beaufort	1	1	1				1
Bethesda	2		2	2			
Bremerton	1	1	1				1
Camp Lejeune		1	1	1			
Camp Pendleton	2	1	2	1	1	1	1
Charleston	1	1	1				
Chelsea	1		1		1		
Corpus Christi			1				1
Great Lakes	1	1	1				
Jacksonville	2	1	1				
Key West			1				1
Memphis	2	1	1				1
Newport	1	1	1	1			1
Oakland	1	1		1		1	
Pensacola	1	2	1				1
Philadelphia	1			1		1	
Portsmouth NH	1		1				1
Portsmouth Va.	4	1	3				
Quantico							1
St. Albans	2	1	1	1			
San Diego	3	3	4	2			1
HAVEN (AH-12)	1	1	1				
TOTAL	28	18	26	10	2	3	12

Preventive Medicine specialists --1 each from PMU No. 2 and PMU No. 6.

NOTE: Each evacuation team to consist of one (1) general medical officer, preferably a Regular medical officer with field experience who, in the opinion of the commanding officer, is capable of carrying out the mission of the team, and ten (10) general duty corpsmen, one of whom is an HM1 or HMC who has had field experience. The mission is to augment the existing medical support capability of ships designated as casualty receiving ships and/or casualty evacuation control ships in the assault phase to handle casualties. Additionally, to augment the medical department of those ships later designated to transport casualties to rear areas. Teams will not be equipped with medical material but will utilize material organic to the ship assigned.

feasible and as many in each specialty as possible should be rotated through these assignments. The use of residents for this duty is not consistent with BUMED's policy of not interrupting residency training unless deemed absolutely necessary. Further, the specialists designated shall be available for immediate assignment when required for augmentation of these units. It is incumbent on commanding officers of naval hospitals to assure that the provisions for medical officers for surgical teams in accordance with reference (b) and for augmentation as outlined herein are not in conflict. The names of the medical officers designated for augmentation and evacuation teams shall be supplied to BUMED semiannually as of 1 September and 1 March. The officers and hospital corpsmen at the time of designation shall be immunized against yellow fever, cholera, and typhus and maintain routine immunizations current.

6. General. BUMED plans to indoctrinate these specialists by ordering them to the course for "Orientation in Field Medicine and Amphibious Operations for Senior Medical Officers" given at Camp Lejeune and Camp Pendleton when hospital staffing and TAD funds permit. A byproduct of this plan should be the development of a permanent cadre of medical officers familiar with the special problems of providing medical care to the Fleet Marine and Amphibious Forces under combat conditions.

A. S. CHRISMAN
Acting

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CG 3RD MARDIV
PMU 6
PMU 2
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Supply Dept., NAVSTA (WASH. NAVYD ANNEX)
Code 514.25,
Washington 25, D. C.

PERSONNEL PLAN FOR AUGMENTATION OF MEDICAL UNITS, FLEET MARINE AND AMPHIBIOUS FORCES

Specialists will be ordered to Fleet Marine and Amphibious Forces from the activities listed below:

SPECIALTY	U.S. NAVAL HOSPITAL	NUMBER TO BE SUPPLIED
Surgeons	Bethesda	3
	Camp Lejeune	1
	Camp Pendleton	2
	Charleston	1
	Great Lakes	1
	Jacksonville	3
	Memphis	1
	Newport	2
	Oakland	1
	Pensacola	1
	Philadelphia	1
	Portsmouth, N.H.	1
	Portsmouth, Va.	4
	St. Albans	2
	San Diego	3
	HAVEN (AH-12)	1
	TOTAL	28
Orthopedic Surgeons	Beaufort	1
	Bremerton	1
	Camp Lejeune	1
	Camp Pendleton	1
	Charleston	1
	Great Lakes	2
	Jacksonville	2
	Memphis	1
	Newport	1
	Pensacola	2
	Portsmouth, Va.	1
	San Diego	3
	HAVEN (AH-12)	1
	TOTAL	18
Anesthesiologists	Beaufort	1
	Bethesda	2
	Bremerton	1
	Camp Lejeune	1
	Camp Pendleton	2
	Charleston	1
	Chelsea	1

SPECIALTY	U.S. NAVAL HOSPITAL		NUMBER TO BE SUPPLIED
Anesthesiologists (continued)	Corpus Christi		1
	Great Lakes		1
	Jacksonville		1
	Key West		1
	Memphis		1
	Newport		1
	Pensacola		1
	Portsmouth, N.H.		1
	Portsmouth, Va.		3
	San Diego		4
	St. Albans		1
	HAVEN (AH-12)		1
		TOTAL	26
Internists	Bethesda		2
	Camp Lejeune		2
	Camp Pendleton		2
	Newport		1
	San Diego		2
	St. Albans		1
		TOTAL	10
Ophthalmologists	Camp Pendleton		1
	Chelsea		1
		TOTAL	2
Psychiatrists	Bethesda		1
	Camp Pendleton		1
		TOTAL	2
Preventive Medicine	PMU Number 6		1
	PMU Number 2		1
		TOTAL	2
Evacuation Teams (Each team to consist of 1 surgeon and 10 general duty corpsmen.)	Annapolis		1
	Beaufort		1
	Bremerton		1
	Camp Pendleton		1
	Corpus Christi		1
	Key West		1
	Memphis		1
	Newport		1
	Pensacola		1
	Portsmouth, N.H.		1
	Quantico		1
	San Diego		1
		TOTAL	12

APPENDIX II

DEPARTMENT OF THE NAVY
Bureau of Medicine and Surgery
Washington 25, D.C.

BUMED 6440.1B
BUMED-31
5 September 1962

BUMED INSTRUCTION 6440.1B

From: Chief, Bureau of Medicine and Surgery
To: Distribution List

Subj: Surgical teams for the operating forces and disaster control

Ref: (a) OPNAVINST P3440.6, Subj: United States Navy Disaster Control Manual (NOTAL)

1. Purpose. To assign certain naval hospitals the responsibility for sponsorship of surgical teams and provide the mission, composition, organization, administration and training guidelines.

2. Cancellation. BUMED Instruction 6440.1A is canceled.

3. Background. Past experience has demonstrated the value of mobile surgical teams assigned to the operating forces of the Navy and Marine Corps for the purpose of expanding the surgical capability of these forces under emergency conditions. In view of the value and mission of these teams, they have been included as a medical element in disaster control measures, whether damage results from natural phenomena or enemy attack. To make surgical teams immediately available to the operating forces for disaster control measures as defined in reference (a), the Chief of Naval Operations has directed this Bureau to issue implementing instructions.

4. Sponsorship. The following hospitals are directed to sponsor surgical teams:

SURGICAL TEAM NO.	U.S. NAVAL HOSPITAL
1	St. Albans, New York
2 and 3	Philadelphia, Pennsylvania
4 and 5	Bethesda, Maryland
6	Chelsea, Massachusetts
7	Charleston, South Carolina
8 and 9	Great Lakes, Illinois
10 and 11	Oakland, California
12 and 13	Portsmouth, Virginia
14 and 15	San Diego, California
16	Yokosuka, Japan
17	Camp Lejeune, North Carolina
18	Camp Pendleton, California
19	Jacksonville, Florida
20	Newport, Rhode Island

5. Function. Surgical teams are designed to provide direct support to fleet and overseas operating forces by augmenting the personnel and material of pre-existing medical facilities when it is anticipated that the number of casualties requiring surgical care may exceed the capabilities of the medical support elements organic to the combat units or operating forces. A secondary mission shall be to provide surgical support and emergency treatment in disaster control measures within and outside the United States.

6. Personnel. One (1) male medical officer qualified in general surgery, one (1) male medical officer qualified in orthopedic surgery, one (1) male medical officer qualified in anesthesiology, and ten (10) male Hospital Corpsmen (six (6) operating room technicians, one (1) field medical technician, one (1) laboratory technician, and two (2) general service) shall constitute the surgical team. Where practicable one of the medical officers shall be a senior officer with field experience. The commanding officer of the sponsoring hospital shall be responsible for assigning alternate or relief members as necessary to maintain a complete surgical team staff available at all times for immediate deployment. The assigned personnel shall be trained as a team to perform traumatic surgery under emergency conditions. The commanding officer shall insure that all members when designated for the team receive the routine required immunizations plus inoculations against yellow fever, cholera and typhus.

7. Training. To provide optimum facilities for training surgical team personnel under field conditions, the Bureau has assigned Surgical Team Supply Blocks (see paragraph 8) to the Commanding Generals of the Marine Divisions at Camp Pendleton and Camp Lejeune. The Commanding Generals, First and Second Marine Divisions are prepared to receive surgical teams for one or two weeks of training. Scheduling shall be arranged by the commanding officer of the hospital sponsoring the surgical team (except Yokosuka) with the Commanding General of the nearest Marine Division. Air transportation shall be requested from the Commandant of the Marine Corps. If such transportation is not available, other Government air or commercial travel shall be utilized. Charges for travel and per diem in connection with this training shall be made to the local O&MN allotment. If any increase is necessary to meet this requirement requests should be directed to this Bureau.

8. Material

a. The material required for outfitting and use of surgical teams is assembled and prepositioned at specific locations and/or held in the Defense Medical Supply System to meet urgent requirements. The material required to initially outfit a surgical team is known as a Medical Equipment Set, Surgical Team Supply Block, FSN L6545-754-0234. This

block provides consumable and nonconsumable material to support the surgical team at an existing facility or semi-independently for approximately 10 days. Resupply material for the surgical team is known as a Medical Equipment Set, Surgical Team Resupply Block FSN L6545-754-0241. This resupply block provides consumable material to extend the capability of the surgical team by approximately 10 days. Logistical data concerning this material may be found in the Supply Management Data Section of the Federal Supply Catalog, DOD Section Medical Materiel, under the standard stock numbers for the blocks.

b. The Field Branch, Bureau of Medicine and Surgery, maintains the list of components of the blocks and will periodically furnish copies of the allowance lists to the sponsoring hospital for familiarization purposes.

9. Administration. The Commanding Officer of each hospital sponsoring a surgical team will be responsible for the administration of that team while it is based at the hospital and the team will be under the Military Command of the Commanding Officer. The ranking medical officer of each surgical team shall be in charge of his team. In the event deployment is ordered, initial charges for travel and per diem will be made to the local O&MN allotment. If any increase is necessary to meet this requirement requests should be directed to this Bureau. When the team is deployed for operation with a fleet or overseas unit it shall be under the Military Command of the Operating Fleet Commander who shall be responsible for administrative and logistic support.

10. Deployment. When needed, competent authority shall submit requests for deployment of surgical teams and material (paragraph 8) to the Chief of Naval Operations, furnishing priorities and complete shipping data. The request shall include the number of supply and resupply blocks required. When directed by the Chief of Naval Operations, the Chief, Bureau of Medicine and Surgery, will direct the cognizant hospital commanding officer to effect the required deployment of a surgical team (personnel). Deployment shall be accomplished by the most expeditious means available, normally through issuance of temporary additional duty orders. The Chief, Bureau of Medicine and Surgery, will also direct the Field Branch, BUMED, Brooklyn, to take the necessary action to effect shipment of the required supply blocks, and resupply blocks if required.

11. Responsibility. The commanding officer of each naval hospital herein designated shall take the necessary action to establish a surgical team and shall be responsible for its training and combat readiness. It is realized that personnel assigned to surgical teams will change from time to time due to transfer, resignation, etc. It is

the responsibility of the commanding officer to insure that an adequate number of personnel assigned to surgical teams have received the necessary field training. Operating force commanders are requested to note the establishment of these surgical teams and the procedures herein provided for their utilization.

A. S. CHRISMAN
Deputy and Assistant Chief

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Additional copies of this Directive may be obtained from: Supply Dept., NAVSTA (Wash. NAVYD Annex, Code 514.25), Washington 25, D.C.

CORRECTED TO:
January 28, 1964

AUTHORIZED ALLOWANCE

SURGICAL TEAM BLOCKS

SURGICAL TEAM SUPPLY

SURGICAL TEAM RESUPPLY

DEPARTMENT OF THE NAVY

BUREAU OF MEDICINE AND SURGERY
Washington 25, D.C.

January 1963

Prepared by

FIELD BRANCH, BUREAU OF MEDICINE AND SURGERY
3RD AVE. AND 29TH ST. ● BROOKLYN 32, N.Y.

PREFACE

SUPERSEDURE NOTICE

This listing of material supersedes that of Oct 1960 and is effective upon receipt.

GENERAL

Detailed information relative to the Surgical Team Blocks listed herein is contained in BUMED Instruction 6700.19B and BUMED Instruction 6440.1B.

WEIGHT-AND-CUBE ESTIMATES

Weight-and-cube information is calculated from the average for each item and its standard container. The following figures are for use as a planning guide and should only be used in the absence of more accurate information:

	WT (LBS)	CU (FT)	DOLLAR VALUE
Surgical Team Supply Block	5,127	207	$13,032
Surgical Team Resupply Block	2,582	106	2,841

SURGICAL TEAM SUPPLY BLOCK

The material contained in this allowance provides consumable and non-consumable supplies for support of a Surgical Team for 10 days. Surgical Teams can only operate with this material from a pre-existing medical facility where sterilization, heating, lighting, and housekeeping facilities are available. The weight and cube of Surgical Team personnel and material permits airlifting.

SURGICAL TEAM RESUPPLY BLOCK

This allowance provides consumable items for a 10-day resupply of a Surgical Team.

FUNCTIONAL PACKING

The functional system of packing the Surgical Team Supply Block allowance, which is indicated herein, was arrived at after extensive testing and evaluation under field conditions. To attain maximum Military/Medical readiness and flexibility, this functional method of packing the component item listings of the Surgical Team Supply Block allowance shall be employed. In implementing this, the following specific instructions apply:

a. Equipment and supplies shall be packed in containers suitable for operations under field conditions in such a manner as to ensure ready accessibility and reuse in the movement of the organization to a new location.

b. Packages or containers shall ordinarily be of such size and weight as to permit handling by two men.

c. Any necessary crating shall be done in such a manner as to permit ready usage by removing either the front, side, or top of the container.

FUNCTIONAL PACKING (Cont'd)

Column identification symbols for Surgical Team Supply Block are as follows:

Functional Purpose	Column Symbol
Anesthesia	AT
General Surgery	GS
Minor Surgery	MS
Eye, Ear, Nose, and Throat	EENT
Orthopedic	OT
Neurosurgical	NS
Supplies and Equipment	S&E
Type of Container recommended	TC

Type of container recommended is as follows:

Container	Symbol
FSN 6545-914-3460 Chest #1	A
FSN 6545-914-3480 Chest #3	B
FSN 6545-914-3500 Chest #5	C
FSN 6545-914-3510 Chest #6	D
Crate	E

It will be noted that the total allowance quantity of each item reflected under the Surgical Team Supply Block column is the sum of the quantities of the item shown in each functional pack.

MODIFICATIONS

Material contained within Surgical Team Supply and Resupply Blocks allowance may be altered or augmented by competent medical authority to provide for requirements peculiar to the specific mission or theater in which employed.

ABBREVIATIONS of Units of Issue

BT Bottle	CN CAN	PR Pair	SL Spool
BX Box	EA Each	RL Roll	TU Tube
CD Card	FT Foot	SE Set	YD Yard
CL Coil	PG Package		

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SURGICAL TEAM BLOCK

Component Item Listing

Federal Stock No.	Description	Unit of Issue	Supply Block Functional Packing									Resupply Block Qty
			AT	GS	MS	EENT	OT	NS	S&E	TC	Total Qty	
KZ 4020-362-4100	CORD COTTON NAT 100 FT	HK								B	1	1
L 4720-141-9080	TUBE RUB 3/16 D1 3/32 W	FT	24						76	B	100	
CX 5110-344-9900	KNIFE CRAFT PLASTER	EA					1			B	1	
N 6135-120-1020	BATTERY BA-30	EA	12						12	B	24	12
~~90~~ 6230-270-5418	FLASHLIGHT ST CELL WT	EA							12	B	12	
L 6240-552-9672	LAMP INCAN 2-7V FROST	EA							2	B	2	2
L 6240-797-2550	LAMP INCAN 1-5V T-3-4	EA	24							B	24	
~~9C~~ 6240-797-3750	LAMP INCAN 3-7V G-3 CLR	EA							2	B	2	2
LL 6505-~~N~~3958-1719	CALCIUM CHL STER 10 cc	PG							1	C	1	1
LL 6505-~~N~~3969-8617	SODIUM LAC SOL 40 cc 6s	BT							3	C	3	3
L 6505-104-8000	ALCOHOL USP 1 QT	CN							7	A	7	7
L 6505-114-5025	COCAINE HYCHL 7-1/2 gr	PG							4	A	4	
L 6505-114-8985	CODEINE SULF TAB 100s	BT							1	A	1	
L 6505-116-1740	DETERGENT SURG 5 oz	BT		12		12	12	12	24	B	72	72
L 6505-116-1890	DEXTRAN INJ 500 cc	PG							18	B	18	18
L 6505-116-4600	DEXTROSE INJ 5-1000 cc	BX							10	B	10	10
L 6505-116-4603	DEXTROSE INJ 10-3 cc	BX	6							B	6	2
L 6505-116-5000	DEXTROSE SOD CHL INJ 6s	BX		2						B	2	2
L 6505-117-4904	EPHEDRINE SUL INJ 12s	BX	8							B	8	8
L 6505-117-5350	EPHEPH INJ LO-POT 12s	BX							2	B	2	2
L 6505-128-3005	MERCURY NF 1 LB	BT							2	B	2	
L 6505-128-5705	THIMEROSAL TINCT 1 PT	BT							1	B	1	
L 6505-130-1440	NITROUS OXIDE 2000 GAL	EA	4							E	4	4
L 6505-132-5225	OXYGEN USP 750 GAL	EA	6							E	6	6
L 6505-133-0810	THIOPENT SOD INJ 1 Gm	BX	4							B	4	4
L 6505-147-1720	TETRACAIN OPH OINT 12s	BX				1				B	1	1
L 6505-147-1820	TETRACAIN HYCHL 10 mg 10s	BX	4						4	B	8	8
L 6505-147-1860	TETRACAIN HYCHL TABS 100	BT							2	B	2	2
L 6505-149-8705	BENZALKONIUM SOL 4 oz	BT						6		B	6	10
L 6505-153-8225	ETHER USP 1/4 LB	CN	100							B	100	100
L 6505-153-8515	SODA LIME USP 5 LB	BT	9							B	9	9
L 6505-153-8651	SODIUM CHL INJ USP 6s	BX		4					1	B	5	5
L 6505-153-8763	NEOSTIGMINE 1-2000 12s	BX	4							B	4	4
L 6505-153-8809	LUBRICANT SURGICAL 4 oz	TU							6	B	6	12
L 6505-160-7410	PROCAINE PENICILLIN 1,500,000 U	BT							150	B	150	150

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			AT	GS	MS	EENT	OT	NS	S&E	TC	Total Qty	
L 6505-160-9510	SPONGE ABS 80-125-10 mm	EA							24	B	24	24
L 6505-261-7245	BENZETHON CHL TAB 4 gr	BT							3	B	3	3
L 6505-263-3362	PHENYLEPHRINE INJ 5 cc	BT	4							B	4	4
L 6505-286-7302	TETRACYCLIN TAB 0.25 Gm	BT							6	B	6	6
L 6505-299-8179	ALBUMIN NORMAL HUMAN SERUM	CN							24	A	24	24
L 6505-299-8276	OXYTET TAB 0.25 Gm 100s	BT							6	B	6	6
L 6505-299-8614	PROCAINAMIDE INJ 10 cc	BT	3							A	3	3
L 6505-299-9475	TUBOCURARINE INJ 6s	BX	20							B	20	20
L 6505-299-9496	LEVARTERENOL INJ 4 cc	BX	2							B	2	2
L 6505-299-9505	POTASS CHL INJ 10 cc 6s	BX							1	B	1	1
L 6505-299-9673	ATROPINE INJ 2 mg 25 cc	BT	5							B	5	5
L 6505-531-7761	DIGOXIN INJ USP 2 cc 12s	BX	6						12	B	18	18
L 6505-543-4048	WATER, INJ USP 5 cc 25s	BX							24	B	24	
L 6505-559-5143	CALCIUM GLUCOHEP INJ	BX							12	B	12	12
L 6505-598-6116	LIDOCAINE INJ 1PC 50 cc	BT	18						18	B	36	36
L 6505-598-6117	LIDOCAINE INJ 2PC 20 cc	BT	12						12	B	24	24
L 6505-720-9680	SUCCINYLCHOLINE 1 Gm	PG	50							B	50	50
L 6505-753-5042	STREPTOMYCIN SULF 1 Gm	BT							150	B	150	150
L 6505-753-9609	HYDROCORTIS SOD 100 mg	BT							6	B	6	6
L 6505-864-7617	MORPHINE INJ 8 mg 20s	PG							3	B	3	
L 6505-864-8096	MEPER HCL INJ 50 mg 20s	PG							9	A	9	9
L 6505-890-1428	DUSTING POWDER SUSP	BX							1	B	1	1
L 6510-200-2185	BAND COT ELAS 2 IN X 5-1/2 YD	PG							1	B	1	1
L 6510-200-2200	BAND COT ELAS 3 IN X 5-1/2 YD	PG							1	B	1	1
L 6510-200-2400	BAND COT ELAS 4 IN X 5-1/2 YD	PG							1	B	1	1
L 6510-200-2500	BAND COT ELAS 6 IN X 5-1/2 YD	PG							1	B	1	1
L 6510-200-3985	BAND GAUZE RL 1 IN X 6 YD	PG							1	B	1	1
L 6510-200-5000	BAND GAUZE RL 3 IN X 10 YD	PG							1	B	1	1
L 6510-200-6000	BAND GAUZE RL 4 IN X 10 YD	PG							1	B	1	1
L 6510-201-1755	BAND MUS 37 X 37 X 52 IN	EA							12	B	12	12
L 6510-201-2001	BAND W/PRF BG 3 IN X 3 YD	PG					24			B	24	24
L 6510-201-2009	BAND W/PRF BG 6 IN X 5 YD	PG					12			B	12	12
L 6510-201-2675	PAD OXID CELL 3 X 3 12s	PG	12							B	12	12
L 6510-201-4205	STRIP COT 3-1/2 X 12 IN 24s	PG							6	B	6	6
L 6510-202-0750	GAUZE PET IMP 3 X 36 IN	PG							10	B	10	10
L 6510-202-8530	PACK GZE ABD 8 X 36 IN 100s	PG							6	B	6	6
L 6510-203-2270	PAD ABD 12 X 16 IN 20s	PG							2	B	2	2
L 6510-203-5500	ADHESIVE PLAS 12 IN X 10 YD	RL							6	B	6	6
L 6510-203-8448	PAD GAUZE 4 X 4 IN 200s	PG							20	B	20	20
L 6510-203-8480	PAD GAUZE 4 X 8 IN 100s	PG							20	B	20	20

Federal Stock No.	Description	Unit of Issue	Supply Block Functional Packing									Resupply Block Qty
			AT	GS	MS	EENT	OT	NS	S&E	TC	Total Qty	
L 6510-203-9000	STOCKINET 3 IN X 25 YD	RL					1			B	1	1
L 6510-204-0000	STOCKINET 6 IN X 25 YD	RL					1			B	1	1
L 6510-204-1000	STOCKINET 10 IN X 25 YD	RL					1			B	1	1
L 6510-204-2000	WADDING COT 5 IN X 6 YD 12s	PG					3			B	3	3
L 6510-299-9597	MASK SURG GAUZE GR 120s	PG							1	B	1	1
L 6510-371-8800	BAND COT P-P 4 X 15 IN 50s	BX					3			B	3	3
L 6510-372-8100	BAND COT P-P 5 X 30 IN 50s	BX					3			B	3	3
L 6510-559-3221	PAD GAUZE 2 X 2 IN 100s	PG							2	B	2	2
L 6510-597-7469	BANDAGE ADH 3/4 X 3 100s	BX							1	B	1	1
LL 6515-NS 969-8622	SURG GUT 1/2 c SZ 000 36s	JR							2	B	2	2
LL 6515-NS 890-1663	DEBAKEY GRAFT 4025	EA							1	B	1	
LL 6515-NS 956-8116	VENOTUBE TWIN SITE	PG							1	B	1	1
LL 6515-NS 890-1662	DEBAKEY GRAFT 4016	EA							1	B	1	
LL 6515-NS 890-1683	SATINSKY VENA CAVA CL	EA							2	B	2	
LL 6515-NS 890-1661	DEBAKEY GRAFT 4054	EA							1	B	1	
LL 6515-NS 890-1682	GLOVER ~~DEBAKEY~~ CLAMP 6-1/2 CMCV	EA							2	B	2	
LL 6515-NS 890-1660	DEBAKEY GRAFT 4050	EA							1	B	1	
LL 6515-NS 890-1681	GLOVER ~~DEBAKEY~~ CLAMP 6-1/2 CMST	EA							2	B	2	
LL 6515-NS 969-8621	SURG GUT 3/8c SZ 00 36s	JR							2	B	2	2
LL 6515-NS 890-1678	DAEMUS BRONCHOS CLAMP	EA							2	B	2	
LL 6515-NS 065-3182	SMITHWICK CLIP FORCEPS	EA							2	B	2	
LL 6515-NS 065-3181	MIXER FORCEPS CV 7-1/2 IN	EA							12	B	12	
LL 6515-NS 890-1654	CROTTI RETRACTOR	EA							2	B	2	
L 6515-246-6452	SCISSORS STR 25 mm CUT	EA		2						B	2	
L 6515-299-8316	PIN STEINMANN 5 IN	EA					4			B	4	4
L 6515-299-8317	PIN STEINMANN 6-1/2 IN	EA					4			B	4	4
L 6515-299-8318	PIN STEINMANN 8 IN	EA					4			B	4	4
L 6515-299-8319	PIN STEINMANN 9 IN	EA					4			B	4	4
L 6515-299-8323	FORCEPS HEMO ANG 7-1/2 IN	EA		2						B	2	
L 6515-299-8324	FORCEPS HEMO ST 7-1/2 IN	EA		2						B	2	
L 6515-299-8325	FORCEPS TISSUE 6 IN	EA		3				3		B	6	
L 6515-299-8337	SUC APP E-P FLD 110V	EA	1	1			1	1		B,C	4	
L 6515-299-8356	CATH URET RND TIP 16F	EA							6	B	6	
~~L 6515-299-8629~~	~~CATHETER MAGILL 40F~~	~~EA~~	~~2~~							~~B~~	~~2~~	
L 6515-299-8687	ANESTHESIA SET INTRATRACHEAL	SE	1							B	1	
L 6515-299-8753	ELEVATOR PERIO HAIG 12	EA							1	B	1	
L 6515-299-8756	RETRACTOR RIB HARKEN	EA							2	B	2	
L 6515-299-9637	NEEDLE HYPO 22 GA 2 IN 12s	BX							1	B	1	
L 6515-299-9638	NEEDLE HYPO 22 GA 2 IN 12s	BX							1	B	1	
L 6515-299-9639	NEEDLE HYPO 22 GA 3 IN 12s	BX							1	B	1	

Federal Stock No.	Description	Unit of Issue	Supply Block Functional Packing									Resupply Block Qty
			AT	GS	MS	EENT	OT	NS	S&E	TC	Total Qty	
L 6515-299-9640	NEEDLE HYPO 22 GA 4 IN 12s	BX							1	B	1	
L 6515-300-2900	AIRWAY GUEDEL RUB LG	EA	8							B	8	
L 6515-301-0430	ANESTHESIA APPARATUS	EA	1							E	1	
L 6515-303-8250	APPLICATOR WOOD COT 1/12 X 6 IN 100s	PG							6	B	6	10
L 6515-307-0090	ATOMIZER MED CLR GLASS	EA				1			1	B	2	
L 6515-309-7900	BATTERY TUB SM W-RHEO	EA							1	B	1	
L 6515-310-2200	BLOCK BITE RUB ADU	EA	1							B	1	
L 6515-310-7840	TRACTOR BONE PIN MED 8-1/2 IN	EA					2			B	2	
L 6515-310-7860	TRACTOR BONE PIN SM 5 IN	EA					2			B	2	
L 6515-310-9140	TRACTOR BONE WI LG	EA					6			B	6	
L 6515-310-9160	TRACTOR BONE WI MED	EA					6			B	6	
L 6515-310-9220	DRILL WI BONE 3/32 IN	EA					1		2	B	3	
L 6515-310-9280	DRILL WI BONE 9 X 35 IN	PG					2		4	B	6	
L 6515-311-8300	TONGS SKULL TRACTION	EA						4		B	4	
L 6515-312-3500	DRILL HAND BONE SMED	EA					1			B	1	
L 6515-312-5320	BRONCH JACK 8 mm X 40 cm	EA					1			B	1	
~~L 6515-316-2150~~	~~CATHETER MAGILL 38 FR~~	~~EA~~	~~2~~							~~B~~	~~2~~	
L 6515-317-4230	CATHETER URET RUB 14F	EA	1						5	B	6	
L 6515-317-4240	CATHETER URET RUB 16F	EA	1						5	B	6	
L 6515-317-4250	CATHETER URET RUB 18F	EA						1	3	B	4	
L 6515-317-4260	CATHETER URET RUB 20F	EA						1	3	B	4	
L 6515-317-5510	CATHETER URET BAL 26F	EA							4	B	4	
L 6515-317-7600	CATHETER URET R-T 18F	EA							4	B	4	
L 6515-317-7620	CATHETER URET R-T 20F	EA							4	B	4	
L 6515-317-7640	CATHETER URET R-T 22F	EA							4	B	4	
L 6515-317-8590	CATHETER URET 28F	EA		4						B	4	
L 6515-317-8670	CATHETER URET 36F	EA		4						B	4	
L 6515-319-1800	CHISEL BONE ALEX ST 3 mm	EA					1			B	1	
L 6515-320-3800	CLAMP PYLORUS PAYR 8 IN	EA		2					2	B	4	
L 6515-320-3840	CLAMP PYLORUS PAYR 11 IN	EA		2					2	B	4	
L 6515-320-4600	FORCEPS TOWEL BACK 5-1/4 IN	EA		12	3	3	12	24		B	54	
L 6515-320-8500	CONTRACTOR RIB BAILEY	EA							2	B	2	
L 6515-321-0680	CABLE ASS ELECT BOEHM	EA	2						2	B	4	
L 6515-321-2900	FINGER COT SURG MED 12s	PG							2	B	2	
L 6515-321-5000	BALOON INTRA CATH 1/4	EA	1							B	1	
L 6515-322-5600	CURETTE MAST SPRA SZ 3	EA					1	1		B	2	
L 6515-322-6800	CURETTE MAST RICH SZ 5	EA					1	1		B	2	
L 6515-323-4510	CUTTER CAST STRY 110V	EA							1	B	1	
L 6515-323-4515	BLADE CAST CUTTER 2 IN	EA							1	B	1	
L 6515-323-4520	BLADE CAST CUTTER 2-1/2 IN	EA							1	B	1	

Federal Stock No.	Description	Unit of Issue	Supply Block Functional Packing									Resupply Block Qty
			AT	GS	MS	EENT	OT	NS	S&E	TC	Total Qty	
L 6515-324-5500	DEPRESSOR TONGUE WOOD 100s	BX							2	B	2	
L 6515-326-2900	DISSECTOR TONSIL HURD	EA				1				B	1	
L 6515-326-8520	TUBE DRAINAGE 18F	EA							4	B	4	
L 6515-327-8400	ELEVATOR PERIO SAYR	EA							2	B	2	
L 6515-328-0700	ELEVATOR PERIO 7-3/4 IN	EA					2	1		B	3	
L 6515-331-1300	FORCEPS BONE CUT CV 10-1/4 IN	EA					1		1	B	2	
L 6515-331-1800	FORCEPS BONE CUT ST 8-3/4 IN	EA					1			B	1	
L 6515-331-2500	FORCEPS BONE HLD ST 10-1/2 IN	EA					2		2	B	4	
L 6515-331-2700	FORCEPS BONE HLD ST 8-1/2 IN	EA					2		1	B	3	
L 6515-331-4600	RONGEUR CUR HARTM 7-1/4 IN	EA					1	1		B	2	
L 6515-331-4800	RONGEUR CUR STILLE 9 IN	EA						1	1	B	2	
L 6515-331-5400	RONGEUR ST STILLE-LUER 9 IN	EA					1		1	B	2	
L 6515-331-7400	FORCEPS BRON LG 60 cm	EA	2					2		B	4	
L 6515-331-9100	FORCEPS BRON REG 50 cm	EA				1				B	1	
L 6515-332-6900	FORCEPS HEMO CL MCKENZ	EA							1	B	1	
L 6515-333-2400	FORCEPS DRESS BAYO 7-1/8 IN	EA							1	B	1	
L 6515-333-3600	FORCEPS DRESS ST 5-1/2 IN	EA		2	2	2	2	4	2	B	14	
L 6515-333-3700	FORCEPS DRESS ST 10 IN	EA		1				1		B	2	
L 6515-333-7600	FORCEPS CONJU ST NONMAG	EA				1				B	1	
L 6515-333-8800	FORCEPS DRESS EYE ST 4 IN	EA				2				B	2	
L 6515-333-9700	FORCEPS FIX ST 4-1/2 IN	EA				1				B	1	
L 6515-333-9900	FORCEPS FIX ST NONMAG	EA				1				B	1	
L 6515-334-0600	FORCEPS STRAB ST 4-1/2 IN	EA				2				B	2	
L 6515-334-1400	FORCEPS GAL DUC CV 7-1/4 IN	EA							10	B	10	
L 6515-334-3800	FORCEPS HEMO CV KEL 5-1/2 IN	EA		10	6	6	12	35	27	B	96	
L 6515-334-4100	FORCEPS HEMO CV MAY 8 IN	EA		9					9	B	18	
L 6515-334-4300	FORCEPS HEMO CV ROCH-P 6-1/4 IN	EA	2	12	2	3	12	10	29	B	70	
L 6515-334-4900	FORCEPS HEMO CV HAL 5 IN	EA		10	10	12	5	10	25	B	72	
L 6515-334-5600	FORCEPS HEMO ST HAL 5 IN	EA		10	10	12	5	12	31	B	80	
L 6515-334-6800	FORCEPS HEMO ST KEL 5-1/2 IN	EA	2	20		6		28	19	B	75	
L 6515-334-7400	FORCEPS HEMO ST ROCH-6-1/4 IN	EA		4				8	4	B	16	
L 6515-334-9500	FORCEPS HEMO CV PEAN 9 IN	EA					2			B	2	
L 6515-335-1900	FORCEPS INT CV DOY 8-3/4 IN	EA		3					4	B	7	
L 6515-335-2800	FORCEPS INT ST BAB 6-1/4 IN	EA		6		2		3	4	B	15	
L 6515-335-3200	FORCEPS INT ST DOY 9 IN	EA		4						B	4	
L 6515-335-5800	FORCEPS KID PEDI 9 IN	EA		2						B	2	
L 6515-335-7300	FORCEPS LARY APPL JACK	EA				1				B	1	
L 6515-335-7600	FORCEPS LARY ANG JAW MED	EA				1				B	1	
L 6515-335-9100	FORCEPS LUNG GRSP COL 8 IN	EA							2	B	2	
L 6515-336-6200	RONGEUR NAS UPCUT	EA						1		B	1	

Federal Stock No.	Description	Unit of Issue	Supply Block Functional Packing								Resupply Block Qty
			AT	GS	MS	EENT	OT	NS	S&E	TC	Total Qty	
L 6515-337-2400	FORCEPS SPLINT 3-1/2 IN	EA		1		1		1		B	3	
L 6515-337-3900	FORCEPS PAD HLD ST 9-1/2 IN	EA		8			5	14		B	27	
L 6515-337-7800	FORCEPS TISSUE ADSON 4-1/2 IN	EA		2						B	2	
L 6515-337-9900	FORCEPS TISSUE TW TY ST 5-1/2 IN	EA		2	2	2	2	4	4	B	16	
L 6515-338-0300	FORCEPS TISSUE ST ALL 6 IN	EA		6	5	5	10	5	15	B	46	
L 6515-338-1200	FORCEPS TISSUE TW TY ST 10 IN	EA				1		1	5	B	7	
L 6515-338-2700	FORCEPS HEMO LEW 7-1/2 IN	EA				6				B	6	
L 6515-339-7840	GLOVES SURGEONS SZ 7	PR							24	B	24	
L 6515-339-7860	GLOVES SURGEONS SZ 7-1/2	PR							60	B	60	
L 6515-339-7880	GLOVES SURGEONS SZ 8	PR							60	B	60	60
L 6515-339-7900	GLOVES SURGEONS SZ 8-1/2	PR							24	B	24	24
L 6515-340-7900	HEAD BAND MIRR LEA JEFF	EA				1				B	1	
L 6515-340-8100	LIGHT HEAD DIAG 3.8V	EA				1				B	1	
L 6515-341-7200	HOLDER NEED COLLIER 5 IN	EA			2	3		3	6	B	14	
L 6515-341-9200	HOLDER NEED HEG-MAYO 7 IN	EA		2	1	2	2	7	4	B	18	
L 6515-341-9800	HOLDER NEED MASS 10-1/2 IN	EA		1	1				2	B	4	
L 6515-342-4700	INHALER ANEST YANKAUER	EA	4							B	4	
L 6515-343-5800	KNIFE AMPUT LISTON 6 IN	EA					1			B	1	
L 6515-344-7800	HANDLE SURG KNIFE NO 3	EA		2	1	1	2	3	2	B	11	
L 6515-344-7820	HANDLE SURG KNIFE NO 4	EA		1	1	1	2	3	2	B	10	
L 6515-344-7880	HANDLE SURG KNIFE NO 7	EA		1		1	1	1		B	4	
L 6515-346-0400	LARYNGOSCOP ADU W-REMO	EA				1				B	1	
L 6515-346-8400	MALLET BONE SURG MET	EA					1			B	1	
L 6515-347-5200	MIRROR 3-1/2 IN DIA	EA					1			B	1	
L 6515-348-7350	NEEDLE ASPIR 13 GA 3-1/2 IN	BX				1		1		B	2	
L 6515-349-1400	NEEDLE INFU 15 GA 2 IN 12s	BX	2							B	2	
L 6515-349-1900	NEEDLE HYPO 17 GA 3 IN 12s	BX	2							B	2	
L 6515-349-2400	NEEDLE HYPO 18 GA 1-1/2 IN	BX	2							B	2	
L 6515-349-3400	NEEDLE HYPO 20 GA 1-1/2 IN	BX	2							B	2	
L 6515-349-3900	NEEDLE HYPO 21 GA 1-1/4 IN	BX	2							B	2	
L 6515-349-4400	NEEDLE HYPO 22 GA 1 IN 12s	BX	2							B	2	
L 6515-349-6400	NEEDLE HYPO 26 GA 1/2 IN	BX	2							B	2	
L 6515-350-5800	NEEDLE SPIPUNC 20 GA 3-1/2 IN	EA	7							B	7	
L 6515-350-5900	NEEDLE SPIPUNC 22 GA 3-1/2 IN	EA	7							B	7	
L 6515-350-9100	NEEDLE SUT 1/2 CIR SZ 12 6s	PG							6	B	6	
L 6515-350-9600	NEEDLE SUT ST 1-3/4 6s	PG							6	B	6	
L 6515-350-9680	NEEDLE SUT ST 2-7/8 6s	PG							6	B	6	
L 6515-351-1200	NEEDLE SUT 1/2 CIR SZ 1 6s	PG							6	B	6	
L 6515-351-1300	NEEDLE SUT 1/2 CIR SZ 4 6s	PG							6	B	6	
L 6515-352-4500	NEEDLE SUT 3/8 CIR SZ 12	PG							6	B	6	

Federal Stock No.	Description	Unit of Issue	Supply Block Functional Packing									Resupply Block Qty
			AT	GS	MS	EENT	OT	NS	S&E	TC	Total Qty	
L 6515-352-4540	NEEDLE SUT 3/8 CIR SZ 16	PG							6	B	6	
L 6515-352-4580	NEEDLE SUT 3/8 CIR SZ 20	PG							6	B	6	
L 6515-352-5140	NEEDLE SUT 1/2 CIR SZ 5 6s	PG							6	B	6	
L 6515-356-9500	PROBE GEN OPER 10 IN	EA		1			1	2		B	4	
L 6515-358-6000	RACK HEMOSTATIC CLIP	EA							1	B	1	
L 6515-360-3490	RETRACT ABD 12 IN X 1 IN	EA		2			2	2	1	B	7	
L 6515-360-3510	RETRACT ABD 12 IN X 5/8 IN	EA		2				1	1	B	4	
L 6515-360-3530	RETRACT ABD 12 IN X 2 IN	EA		4						B	4	
L 6515-360-3850	RETRACT ABD DBLE END	SE		2			1	1		B	4	
L 6515-360-4910	RETRACT ABD SLF RET	EA		2						B	2	
L 6515-360-6600	RETRACT MAST WEITLANER	EA				4				B	4	
L 6515-360-7900	RETRACT EYELID 5-1/2 IN	EA				2		1		B	3	
L 6515-360-9200	RETRACT GEN OPER SE 2	SE		1	1	1	1	2	6	B	12	
L 6515-361-0350	RETRACT GEN OPER 4 PRG	EA		2	2	2	2		4	B	12	
L 6515-361-3200	RETRACTOR LAMINECTOMY	EA							1	B	1	
L 6515-361-3950	RETRACT MAST JANSEN	EA				3		2		B	5	
L 6515-361-8200	ELEVATOR RETRAC BONE	EA							1	B	1	
L 6515-361-8980	RETRACT TRACH 3 SHP PRG	EA				2				B	2	
L 6515-362-0200	RETRACTOR VEIN CUSHING	EA					2	2		B	4	
L 6515-363-1100	SAW AMPUT 8 IN BLADE	EA					1			B	1	
L 6515-363-2300	CONDUCTOR BONE CUT SAW	EA					2			B	2	
L 6515-363-2400	HANDLE BONE CUT WI SAW	PR					1	1		B	2	
L 6515-363-2700	SAW BONE CUT WI 20 IN	EA					5	9	16	B	30	
L 6515-363-8840	SCISSORS BAND ANG 7-1/4 IN	EA	2	1	1	1	1	1	7	B	14	
L 6515-364-0520	SCISSORS GEN SURG 6-3/4 IN	EA		2		1	1	2		B	6	
L 6515-364-0560	SCISSORS GEN SURG 9 IN	EA							2	B	2	
L 6515-364-0920	SCISSORS GEN SURG 6-3/4 IN	EA		1	1	1	1	2		B	6	
L 6515-364-4600	SCISSORS IRIS FC 4-1/4 IN	EA				1		1		B	2	
L 6515-364-4800	SCISSORS IRIS ST 4-1/4 IN	EA				1		1		B	2	
L 6515-365-1820	SCISSORS GEN SURG ST 5-1/2 IN	EA							2	B	2	
L 6515-365-5200	SCISSORS STRAB ST 4-1/4 IN	EA				1		1		B	2	
L 6515-365-7100	SCISSORS TNSL CUR 7 IN	EA		6		1		2		B	9	
L 6515-366-9200	FORCEP BONE CUT 13-1/2 IN	EA		1				1		B	2	
L 6515-368-4400	SPATULA BRAIN CUSHING	EA							2	B	2	
L 6515-371-3100	SPHYGMOMANOMETER ANER	EA	2						6	B	8	
L 6515-371-9600	SPLINT ARM ADULT	EA							4	E	4	2
L 6515-372-5100	SPLINT LEG HLF-RG ALUM	EA							6	E	6	3
L 6515-372-9800	SPLINT LEG ADJ PLYWOOD	EA							6	E	6	3
L 6515-373-2100	SPLINT WI LAD 3-1/2 X 31 IN	EA							30	E	30	15
L 6515-373-7800	SPREADER PL CAST HENN	EA							1	E	1	

Federal Stock No.	Description	Unit of Issue	Supply Block Functional Packing									Resupply Block Qty
			AT	GS	MS	EENT	OT	NS	S&E	TC	Total Qty	
L 6515-374-2200	STETHOSCOPE B/PRESSURE B-T	EA	2						1	B	3	
L 6515-374-2220	STETHOSCOPE COMB TYPE	EA	1						14	B	15	
L 6515-374-4800	STOPCOCK SUR 3 WAY AYER	EA	16							B	16	
L 6515-374-6900	ELEV PERIO MATS 8-3/4 IN	EA							1	B	1	
L 6515-375-2500	SUCTION APP PORT 110V	EA							1	C	1	
L 6515-375-5200	SUTUR NONAB CRS 32 GAGE	SL							4	B	4	4
L 6515-375-5240	SUTUR NONAB CRS 28 GAGE	SL							1	B	1	1
L 6515-375-5320	SUTUR NONAB CRS 22 GAGE	CL							1	B	1	1
~~L 6515-375-5540~~	~~SUTURE COT SZ 1 100 YDS~~	~~SL~~							~~4~~	~~B~~	~~4~~	~~2~~
~~L 6515-376-5680~~	~~SUTURE SILK BR SZ 0 12s~~	~~PG~~							~~2~~	~~B~~	~~2~~	~~1~~
~~L 6515-376-5720~~	~~SUTURE SILK BR SZ 2 12s~~	~~PG~~							~~2~~	~~B~~	~~2~~	~~1~~
~~L 6515-377-5940~~	~~SUTURE SILK TW SZ 5-0 12s~~	~~PG~~							~~4~~	~~B~~	~~4~~	~~2~~
L 6515-377-7380	CLIP HEMO MCKEN SIL 100	PG							2	B	2	
L 6515-378-4180	SUTURE NONAB MT SZ 1 12s	PG		2						B	2	2
L 6515-379-4400	SYRINGE GLASS 3 OZ	EA	1	1			1	1	8	B	12	
L 6515-380-4100	SYRINGE LUER 10 cc	EA	2						19	B	21	6
L 6515-380-4300	SYRINGE LUER 20 cc	EA	6						9	B	15	6
L 6515-380-4500	SYRINGE LUER 30 cc	EA	1						13	B	14	3
L 6515-380-8205	SYRINGE NEEDLE SET	SE	1		1			1		B	3	
L 6515-383-0400	TOURNIQUET PNEUMATIC	EA					1		1	E	2	
L 6515-383-8900	TROCAR DRAIN 28F	EA		1						B	1	
L 6515-384-5100	CANNULA BRON ESOPH 50 cm	EA				1				B	1	
L 6515-384-6950	CANNULA BRON OPEN 40 cm	EA				1				B	1	
L 6515-385-9200	TUBE DUO MIL-AB DBLU 16F	EA							6	B	6	
L 6515-385-9880	TUBE DUO LEVIN 16F	EA							6	B	6	
L 6515-386-6600	CANNULA ABD POOL 23F	EA		1			1	1		B	3	
L 6515-386-6800	CANNULA BRAI FRAZ 8F	EA						2		B	2	
L 6515-386-7600	CANNULA LARY YANK	EA							4	B	4	
L 6515-386-9580	CANNULA TRACHE SZ 4	EA	1			1		1		B	3	
L 6515-386-9660	CANNULA TRACHE SZ 6	EA	1			1		1		B	3	
L 6515-386-9700	CANNULA TRACHE SZ 7	EA	3							B	3	
L 6515-387-4100	TUBE PENROSE 3/8 IN	EA							12	B	12	
L 6515-387-4140	TUBE PENROSE 5/8 IN	EA							12	B	12	
L 6515-387-4180	TUBE PENROSE 7/8 IN	EA							12	B	12	
L 6515-388-9900	WAX BONE STERILE	TU	1	1						B	2	2
L 6515-514-2395	SYRINGE LUER 2 cc	EA	2						18	B	20	10
L 6515-515-2113	BRACE BIT BONE CRAN HUD	EA							1	B	1	
L 6515-515-2114	BUR CRANIAL HUDS 9 mm	EA							1	B	1	
L 6515-515-2115	BUR CRANIAL HUDS 16 mm	EA							1	B	1	
L 6515-515-2116	DRILL FLAT CRANIAL 3/8 IN	EA							1	B	1	

Federal Stock No.	Description	Unit of Issue	Supply Block Functional Packing									Resupply Block Qty
			AT	GS	MS	EENT	OT	NS	S&E	TC	Total Qty	
L 6515-550-6925	TUBE INTRA PLAS 0.023	BX	1	1						B	2	2
L 6515-550-6926	TUBE INTRA PLAS 0.034	BX	1	1						B	2	2
L 6515-550-7199	OTOSCOPE-OPTH SE BATT	SE							1	B	1	
L 6515-550-7200	OTOSCOPE BATTERY TYPE	EA							2	B	2	
L 6515-558-1509	BLOOD REC SE DISP FLD	SE							72	B	72	72
L 6515-559-6885	SUTURE AB MT SZ 3-0 12s	PG							3	B	3	
L 6515-582-5043	SUTURE NONAB MILD SZ 5-0	PG							8	B	8	3
L 6515-584-2628	TUBE CON PLAS DISP 20s	PG	3							B	3	3
~~L 6515-616-9441~~	~~SUTURE COT TW SZ 00 12s~~	~~PG~~							~~12~~	~~B~~	~~12~~	~~12~~
~~L 6515-616-9442~~	~~SUTURE COT TW SZ 000 12s~~	~~PG~~							~~12~~	~~B~~	~~12~~	~~12~~
~~L 6515-616-9443~~	~~SUTURE COT TW SZ 4-0 12s~~	~~PG~~							~~12~~	~~C~~	~~12~~	~~12~~
~~L 6515-616-9444~~	~~SUTURE SILK BR SZ 00 12s~~	~~PG~~							~~24~~	~~C~~	~~24~~	~~24~~
L 6515-616-9445	SUTURE SILK BR SZ 000 12s	PG							24	C	24	24
L 6515-616-9446	SUTURE SILK BR SZ 4-0 12s	PG							24	C	24	24
L 6515-616-9447	SUTURE NONAB MILD SZ 00 SA	PG							4	C	4	2
L 6515-616-9448	SUTURE NONAB MILD SZ 1	PG							2	C	2	2
L 6515-616-9449	SUTURE NONAB MILD SZ 0	PG							2	C	2	2
L 6515-616-9450	SUTURE NONAB MILD SZ 00	PG							4	C	4	4
L 6515-616-9451	SUTURE NONAB MILD SZ 000	PG							8	C	8	8
L 6515-616-9453	SUTURE AB SZ 0	CN							6	C	6	
~~L 6515-616-9454~~	~~SUTURE NONAB PLAIN SZ 00~~	~~PG~~							~~9~~	~~C~~	~~9~~	~~4~~
~~L 6515-616-9455~~	~~SUTURE NONAB PLAIN SZ 000~~	~~PG~~							~~3~~	~~C~~	~~3~~	
L 6515-660-0007	BLADE KNIFE NO 21 6s	PG							10	C	10	10
L 6515-660-0008	BLADE KNIFE NO 15 6s	PG							10	C	10	10
L 6515-660-0011	BLADE KNIFE NO 10 6s	PG							20	C	20	20
L 6515-660-0012	BLADE KNIFE NO 20 6s	PG							10	C	10	10
L 6515-660-0046	AIRWAY PLASTIC AD-CHILD	EA							2	C	2	
L 6515-664-5398	CHISEL BONE STR 1/2 IN	EA					2			B	2	
L 6515-664-5399	CHISEL BONE STR 3/4 IN	EA					1			B	1	
L 6515-664-7853	RETRACTOR OPER FLEX	SE		1				1		B	2	
L 6515-754-0425	RAZOR SURG PREP STR TY	EA	1	1			1	2		B	5	
L 6515-754-0426	BLADE SURG PREP RAZOR 5s	PG							10	B	10	
L 6515-793-2000	THERMOMETER ORAL	EA							12	C	12	12
L 6515-793-2075	THERMOMETER RECTAL	EA							12	C	12	12
L 6515-817-1201	TUBE CONNECTING SUR AP 12s	PG							3	B	3	3
L 6515-889-7448	INTRAVEN INJ DIS FLD	SE							72	B	72	72
L 6530-299-8292	STER INST ELEC F-H	EA							3	B	3	
L 6530-299-9599	WRAPPER STER GR 36 IN SQ	EA					6		19	C	25	
L 6530-299-9600	WRAPPER STER GR 24 IN SQ	EA					6		44	C	50	
L 6530-299-9601	WRAPPER STER GR 18 IN SQ	EA		6					19	C	25	

Federal Stock No.	Description	Unit of Issue	Supply Block Functional Packing								Total Qty	Resupply Block Qty
			AT	GS	MS	EENT	OT	NS	S&E	TC		
L 6530-299-9602	WRAPPER STER GR 12 IN SQ	EA							25	C	25	
L 6530-299-9603	WRAPPER STER GR 12 X 13 IN	EA		6					54	C	60	
L 6530-299-9607	DRAPE SURG GR 34 X 66 IN	EA		1					10	C	11	3
L 6530-299-9821	TAPE SEN ADH 1 IN X 60 YD	RL							10	C	10	5
L 6530-299-9822	TAPE SEN ADH 1/2 IN X 60 YD	RL							10	B	10	5
L 6530-551-8681	STAND SUR INST ADJ FLD	EA							3	E	3	
L 6530-663-1556	PIN CUR ORTH MED 12s	CD	1	1					8	C	10	5
L 6530-706-6300	LIGHT SURG FLD 110V	EA		1					1	B	2	
L 6530-708-5320	INDICAT STER TAB-TU 100s	BX							1	B	1	1
L 6530-709-8155	TABLE OPERATING FIELD	EA							1	E	1	
L 6530-770-6425	BAG HOT WATER-ICE	EA							3	B	3	3
L 6530-770-9220	BASIN EMESIS CRS	EA	1	1				2		B	4	
L 6530-772-0326	BOWL GZ PAD CRS	EA	1	1			1	2	4	B	9	
L 6530-780-7000	MEDICINE GLASS 1 OZ	EA	2	2	1	2	2	4	2	B	15	
L 6530-782-7075	JAR DRESS CRS	EA							6	E	6	
L 6530-782-7180	JAR FORCEPS CRS	EA							3	B	3	
L 6530-782-7400	JAR SURG NEEDLE CRS	EA							3	B	3	
L 6530-793-9570	TRAY CRS 19 X 12 X 3/4 IN	EA							6	E	6	
L 6530-793-9945	TRAY INST CRS 10 X 8 X 2 IN	EA							7	E	7	
L 6530-794-0000	TRAY INST CRS 15 X 9 X 2 IN	EA	1	1			1	2	1	B	6	
L 6532-299-9613	CAP OPER SURG LG GR	EA							40	D	40	
L 6532-299-9614	CAP OPER SURG MED GR	EA							40	D	40	
L 6532-299-9624	GOWN OPER SURG LG GR	EA							39	D	39	
L 6532-299-9625	GOWN OPER SURG MED GR	EA							38	D	38	
L 6545-911-1300	BLANKET SET BED SMALL	SE							1	E	1	
L 6545-914-3460	CHEST NO 1 24 X 12 X 6 EMP	EA									3	
L 6545-914-3480	CHEST NO 3 30 X 18 X 10 EMP	EA									25	5
L 6545-914-3500	CHEST NO 5 30 X 18 X 16 EMP	EA									3	
L 6545-914-3510	CHEST NO 6 30 X 18 X 20 EMP	EA									2	
L 6545-925-9200	TRAY INSTR-SUP CHEST	EA							1	A	1	
L 6545-926-1460	LABORATORY EQUIP FIELD	SE							1	A,C	1	
L 6545-927-4960	SURGICAL INSTR INDIVIDUAL	SE								A	2	
L 6640-290-5749	PIPET RED CORPUSCLES	EA							6	C	6	6
L 6640-418-0800	CLAMP SCREW ADJUSTMENT	EA							12	D	12	12
L 6640-424-7100	FLASK ERLENMEYER 4000 ML	EA							6	D	6	
L 6640-427-5055	GRADUATE ENAMEL 60 ML	EA	1						2	D	3	
L 6640-427-6935	PIPET WHITE CORPUSCLES	EA							6	C	6	6
L 6640-428-1400	PIPET SERO DILUTING	EA							4	C	4	4
L 6640-438-5950	ROD ASSOR STIRRING 1 LB	PG							1	D	1	1
L 6640-445-4100	CONNECTOR EL Y-SHAPE 5 mm	EA							12	D	12	

Federal Stock No.	Description	Unit of Issue	Supply Block Functional Packing									Resupply Block Qty
			AT	GS	MS	EENT	OT	NS	S&E	TC	Total Qty	
L 6640-445-4105	CONNECTOR EL Y-SHAPE 8 mm	EA	12							B	12	
L 6810-143-7000	SODIUM NITR ACS 1 OZ	BT							10	D	10	11
L 7210-717-2000	SHEET BED COTTON WHITE	EA							75	B	75	
D 7210-717-8000	TOWEL HAND	EA							212	B	212	
L 7240-771-0945	BASIN WASH CRM 4-1/4 QT	EA		1			1	2	1	E	5	
L 7240-773-0975	PAIL CRM 12 QT	EA							5	E	5	
CX 7350-735-2465	PITCHER WATER 1-1/8 QT	EA		1				1		B	2	
CX 7530-222-3524	BOOK MEMO	EA							3	D	3	
L 7920-772-5935	BRUSH SCRUB	EA							12	D	12	
6532 L ~~8125~~-430-5436	JAR OINT 1 LB	EA							4	D	4	
6640 L ~~8125~~-442-2000	STOPPER RUB 2 HOLE NO 7	EA							6	D	6	
L 8305-330-0100	FELT WOOL GRAY 1/4 IN	YD							1	B	1	2
L 8305-790-0000	CLOTH RUBBER 54 IN WIDE	YD					1		2	D	3	
L 6515-531-7884	SUTURE, SILK, BR, SZ 0	PG									4	2
L6515-982-7164	SUTURE, COT, TW, SZ 000, 12''	PG									4	4
L6515-469-8693	SUTURE, ABS, UNDYED, SZ 000, 12''	PG									6	6
L6515-461-5525	CATHETER, MAGILL, 36 cm	EA									2	
L6515-983-7163	SUTURE, COT, TW, SZ 4-0, 12''	PG									1	1
L6515-963-7157	SUTURE, COT, TW, SZ-00, 12''	PG									2	2
L6515-983-7155	SUTURE, COT, TW, SZ-1, 12''	PG									20	10
L6515-963-5352	SUTURE, UNDYED, SILK, BR, SZ 5-0	PG									4	2
L6515-616-9446	SUTURE, UNDYED, SILK, BR, SZ 4-0	PG									24	24
L6515-454-8116	TUBE, CONNECT, PLAS	PG									1	1

APPENDIX IV

BATTLE CASUALTIES
3-3 2nd Medical Battalion, 2nd Mar Div, FMF, CLNC

A. Comment: In planning the medical operation of a Battalion Aid Station or a Collecting and Clearing Company, it is of value to have some estimation of the type and number of casualties that could be expected in combat, the usage rates of blood and the speed of evacuation. Though such information on a battle situation is obviously hard to obtain, several books and manuals have attempted to put together these figures. These books have been reviewed, and the following abstract of the more interesting information is appended.

It is understood, that the figures represent averages and that in actuality the extremes will present as often as not. Yet, some type of basic guide line of concept is useful in order to have a framework to begin with should an actual present day combat situation superimpose itself.

The following figures are derived from the book "Battle Casualties," by Beebe and Debakey reporting WW II experiences (approx. 1941-1945), and the Medical Science Publications from the Walter Reed Army Medical Center on the Korean Conflict (1950-53).

1. Percentage distribution of major wounds among infantry wounded. Figures include both WWII Theaters of action 1944-1945.

Region	Tot. hits	Killed	Wounded	Died of wounds	Living w'nd.	Armor*	All Deaths
Head, neck	21%	47%	15%	22%	14%	15%	43%
Thoracic	13	25	10	23	10	3	25
Abdominal	8	15	6	24	5	5	17
Upper Extrem.	23	5	28	7	29	32	5
Lower Extrem.	35	8	41	24	42	45	10
TOTAL	100%	100%	100%	100%	100%	100%	100%

* - assumed % change of wounded had armor been used (body)

2. Result of hits upon ground troops, excluding lightly wounded who lost no time from battle: (WWII)

IN EVERY 100 HIT: 19.7 KIA/3.6 Died of wounds

3. Specific Wounds. (WWII)

a. Peripheral nerve injuries...occurred in 5.8 ± 1.7% of all Army wounded. They occurred in 8.4 ± 2.4% of all extremity wounds.

b. Arterial wounds...occurred in 1% of all wounds. Of those which

involved extremities 40% lost the affected limb. An arterial wound was the primary cause of 19% of all major amputations.

c. Amputations (excluding fingers, toes)

(1) 2.8% of all living wounded. Involved 2% of all upper extremity wounds and 5.3% of all lower extremity wounds.

(2) Of all amputations, 21.1% involved the upper extremity while 78.9% involved the lower extremity.

(3) 91% of all amputation lived to be evacuated.

(4) Of all amputations, 69% were caused by traumatic amputation. 19% were due to arterial injury, and 12% were caused by infection.

d. Figures concerning burns are not clear. In one section it was stated that burns would be 1.2% of all wounds if burns were included as a major injury. This comment was made of the period of 1944-45. Note that NAPON was introduced about 1944.

4. Primary and secondary causes of death in field hospitals, WWII.

	Primary	Secondary
a. hemorrhage and shock	41.7%	11.2%
b. infection	21.8%	16.7%
c. circulatory failure	9.5%	1.9%
d. neurologic	7.8%	1.4%
e. urologic	5.3%	1.4%
f. pulmonary edema	2.5%	9.4%
g. anesthesia	2.3%	2.9%
h. GI disease	1.5%	0.2%
i. miscellaneous	7.6%	54.9%

5. Specific Distribution of wounds - note that if a Regiment is approximately 3,500 men then the figures noted below happen to correspond to the absolute number of casualties which might be expected in a Regiment during a time of heavy casualties. (WWII)

Considering that the landing has been made, then experience with the Marine Corps during the Pacific campaigns shows that the heaviest fighting produced a maximum of 25.98 men wounded/per day/per 1000 men. The average was 10.37 men wounded/per day/per 1000 men; and the minimum was 4.90 men wounded/per day/per 1000 men.

The figures below include only wounds. Observe that nothing is said about non-battle casualties. In this regard, note that certain of the Pacific battles produced non-battle casualties as many as 50-75% of the combat ineffectives!

Region	A. Heavy Cas.	DOW	Severe	Others	B. Av. Cas.	DOW	Severe	Other Mod.sev.
1) Head								
Intra-cranial	2	1	1	0	1	1	0	0
scalp	4	0	0	0	2	0	0	0
2) Eye and Ear	2	0	0	0	1	0	0	0
3) Neck	2	0	0	1	1	0	0	0
4) Maxil facial								

Region Cont'd	A. Heavy Cas.	DOW	Severe	Others	B. Av. Cas.	DOW	Severe	Other Mod.Sev.
bone	1	0	0	1	1	0	0	0
Soft tissue	4	0	0	0	2	0	0	0
5) Chest								
intrathor	4	1	2	1	2	0	1	1
superficial	4	0	0	0	1	0	0	0
6) Spine	1	0	1	0	±1	0	1	0
7) Abdominal								
Intra-abdom.	3	1	2	0	1	1	0	0
Thoracoabdom.	1	0	1	0	±1	0	1	0
Superficial	1	0	0	0	±1	0	0	0
8) Extremities								
Deep muscle	34	0	31	3	14	0	10	4
Compound Fx.	12	1	4	7	5	0	5	0
Traumatic amp.	3	1	2	0	1	0	0	1
Superficial	14	0	0	0	6	0	0	0
9) Miscellaneous	2	0	0	0	±1	0	0	0
TOTAL	94	5	44	13	42	2	18	6

All wounds not included under the headings of DOW, "severe" or "mod. severe" are presumed to be of minor degree with little danger to life.

6. Time intervals for evacuation

It should be noted that the field hospitals involved in this study were located approximately 10 miles behind battle lines - a situation similar in both WWII and the Korean conflict. The reason for the improvement of evacuation time is not apparent, but may possibly have some relation to the use of helicopters for this purpose.

The field hospital used in these figures is no longer in existence in the Marine Corps Medical System. This was the Hospital Company (in contradistinction to the Collecting and Clearing Company) of the Medical BN which was dropped from the T/O in 1957. This naturally creates some question as to what equivalent evacuation statistics would be with the present T/O.

	WWII	KOREA
Time from injury to admission	5.6 hrs	3.1 hrs
Time from admission to surgery	3.4 hrs	3.2 hrs
Time from injury to surgery	8.9 hrs	6.3 hrs

7. Average operating time during Korean conflict in field hospitals

a. Thoraco-abdominal and abdominal	2.4 hrs
b. Thoracic	1.6 hrs
c. Amputation	1.6 hrs
d. Compound Fracture	1.3 hrs

8. Utilization of surgeons - WWII

The average surgeon in the field hospital performed an average of 7 procedures per day. In "Battle Casualties", Beebe and Debakey state that at a time of peak capacity surgeons were capable of performing an average of 10.5/day/surgeon but only for a maximum period of 3 days. At the end of this time, all members of the operating team were working on such low efficiency that a rest period had to be established.

An average of one anesthetist worked with 2 surgical teams.

9. Collecting and Clearing Company Statistics. 1961

It may be of interest to note the capabilities of a C&C Company of this Division - the figures for which were derived from a recent test of the operating room unit of one company.

The operating room unit can be completely set up by the T/O of 6 operating room technicians and 1 general service corpsman - tentage, sterile supplies and scrub area - and be ready to start the incision of the 1st case in 2 hrs. 45 min. to 3 hrs. after the combat loaded trucks arrive at the company area.

Using the 3 Basic Minor Sets and 1 Basic major set contined in the company, it is possible to run a maximum of 20 cases per 24 hour period (using the average operative times as above) assuming all hands, all autoclaves and all equipment are in use full time.

10. Experience with resuscitative fluids in one Army Field Hospital, Korea.

		Blood Transfusion in C.C's			
Type Wound	Cases	Preadmiss Rx	Preop Rx	Oper Rx	1st 24 hrs postop Rx
a. Abdominal	70	264	1,464	1,467	3,428
b. Thoraco-abd	29	103	1,308	1,187	2,867
c. Thoracic	33	75	1,088	333	1,890
d. Amputation	30	469	1,403	1,407	3,500
e. Compound Fx.	82	47	380	448	926

NOTE:

1. Most of the fluid Rx noted above given prior to admission to the field hospital was Dextran; thereafter it was whole blood.

2. In Korea, the casualties which died in the field hospital, more than 50% died because of uncontrolled hemorrhage.

3. In WWII in one study of 254 cases who died in shock after surgery in a field hospital - 82% received no blood during or after surgery; 18% received no blood prior to operation.

ARMY REGULATION
No. 40-562
BUMED INSTRUCTION
No. 6230.1D
AIR FORCE REGULATION
No. 161-13

DEPARTMENTS OF THE ARMY, THE NAVY AND THE AIR FORCE

WASHINGTON, D.C., *10 December 1963*

MEDICAL SERVICE

IMMUNIZATION REQUIREMENTS AND PROCEDURES

1. General. This regulation defines general principles and specific procedures to be followed in the prophylactic immunization programs of the armed forces. This regulation implements the immunization requirements contained in STANAG (NATO Standardization Agreement) Number 2037. In this regulation when the designation "United States" is used, the 50 United States and District of Columbia are included. Prophylactic immunization will be construed to include the use of any vaccine, toxoid, or other immunizing agent for the prevention of disease including the maintenance of immune status by reimmunization (booster immunization). See TB MED 114/NAVMED P-5052-15A/AFP 161-1-9.

2. Responsibility. Commanding officers are responsible for assuring that all individuals under their jurisdiction receive required immunizations and that appropriate records of such immunizations are maintained. If warranted by local conditions, authority to deviate from the specified immunizations and reimmunizations may be granted by the appropriate Surgeon General upon request supported by pertinent justification. If deviation would affect personnel of more than one armed service or such personnel traveling to or through the area, authority to deviate will be granted only by concurrent action of the Surgeons General of the affected services.

3. Standards. *a.* All biologicals procured in the United States for use by the armed forces will meet the minimum requirements of the National Institutes of Health, U.S. Public Health Service, Department of Health, Education, and Welfare, for the production and sale of such materials. Immunizing agents procured from sources not licensed by the Department of Health, Education, and Welfare will meet standards equivalent to those of the National Institutes of Health. Such procurement must be specifically authorized by the appropriate Surgeon General.

***This regulation supersedes AR 40-562/BUMEDINST 6230.1C/AFR 161-13, 5 September 1962, SUP-1 of 19 April 1963, BUMEDNOTES 6230 of 13 November 1962, and 9 July 1963.**

b. Immunizing agents will not be used beyond the stated expiration dates unless the appropriate Surgeon General has specifically authorized extension.

4. Requisitions. Immunizing agents will be requisitioned in accordance with current medical supply procedures. (*Navy only:* However, in order to minimize the shipments of vaccines that must be kept frozen (i.e., the items coded "W" in the Federal Supply Catalog, DOD Section, Medical Materiel), small stations and ships may obtain these items on a pickup basis from the nearest military medical activity (hospital, station hospital, dispensary, etc.) that carries the items in stock. Requisitioning procedures and reimbursement in such instances will be as prescribed by the supplying activity.)

5. Preservation. *a. Vaccines which must be kept frozen.* Oral poliovirus vaccine and yellow fever vaccine will always be distributed and stored at temperatures below 0° C. (32° F.). When possible, storage will be at −18° to −15° C. (0° to 5° F.) or lower. Shipments will be made in a manner which will insure maintenance in the frozen state at all times, i.e., in dry ice packing or in mechanical freezing units. Thawing or evidence of thawing during shipment renders the shipment unacceptable for use. See *c* below for disposition procedures.

b. Other biologicals. All other biologicals will be stored at temperatures between 2° and 10° C. (35.6° to 50° F.) and *will not be frozen.* The vial in which freeze-dried smallpox vaccine is reconstituted and the assembly for administration contain live virus. Before these items are discarded, they should be burned, boiled, or autoclaved to prevent accidental vaccination by breakage during disposal. These biologicals will be shipped under temperatures prescribed for storage when practicable. See paragraph 3, TB MED 114/NAVMED P–5052–15A/AFP 161–1–9.

c. Identification and disposition of suspect vaccines. Shipments will not be accepted for use if there is change in the physical appearance or evidence of bacterial contamination or growth. Shipments received which show evidence of alteration in physical appearance or bacterial contamination or which have a history of having been subjected during shipment to temperatures varying from those indicated in *b* above will be withheld from issue. A request for disposition instructions citing identifying data, circumstances, and deficiencies noted will be forwarded to the supply source with information copy to the appropriate Surgeon General. (USAF—follow ch. 10, vol. V, AFM 67–1.)

6. Intervals. The prescribed time intervals between individual doses of a basic inoculation series for immunization is to be regarded as optimal and adhered to as closely as possible. If a delay should occur in the completion of a series, the next dose or doses will be administered at the earliest opportunity. *A new series will not be given. The prescribed minimal intervals between doses will not be reduced under any circumstances.* (*Navy only:* Commanders of recruit training centers are authorized to employ delayed schedules among recruits in the presence of outbreaks of acute respiratory disease in their commands.) When a basic series has been completed under military control, as evidenced by proper entries on SF 601 (Health Record—Immunization Record), DD Form 737 (DOD Immunization Certificate), or equivalent DA Form 8–117 (Immunization Register) replaced by DD Form 737, AF Form 1711 (Health-Immunization Record), the identification tag, or other official military record, the need for another basic series of that agent is eliminated. A stimulating dose will be administered, as indicated.

7. Sensitivity. Prior to the injection of any biologic product, determination of whether the individual has previously shown any unusual degree of sensitivity to a foreign protein will be made. Individuals who give a history of sensitivity to an immunizing agent usually should be exempted from that immunization. Persons with significant allergy to eggs or fowl should not be given vaccine prepared by cultivation in eggs (e.g. typhus, influenza, yellow fever, or measles). Severe individual reactions of sensitivity to any biologic agent or drug will be recorded in the immunization records, indicating the offending substance, its lot number and manufacturer, the date administered and severity of reaction. Prior to the administration of any immunizing agent, provision

will be made for the immediate first aid and medical care of any anaphylactoid reaction which may occur. Wherever immunizations are given, an emergency tray, with tourniquet and a syringe containing a 1:1,000 solution of epinephrine will be on hand *ready for immediate use.* For additional information regarding emergencies, see TB MED 114/NAVMED P–5052–15A/AFP 161–1–9.

8. Undesirable reactions. *a.* Whenever local or constitutional reactions of unexpected severity or frequency, local infection, or abscess formation not traceable to errors in techniques of administration, or other significant manifestations occur which may be due to the use of a biologic product, further administration of that lot will be discontinued. Communication with the surgeon (staff medical officer) at the next higher headquarters is encouraged. Request for instructions regarding disposition of suspected material will be made in compliance with DSAR 4140.7/AR 700–6500–15, FMSO FLDBR BUMED INST 6700.16 series, or chapter 6, volume V, AFM 67–1. The biologic material under suspicion will be retained, including both open and unopened packages, pending receipt of instructions for disposition of the suspected materials.

b. All aircrews will be grounded a minimum of 8 hours (24 hours if not detrimental to mission) after receiving any immunization except oral poliovirus vaccine and smallpox vaccination.

9. Permanent exemptions and temporary waivers. *Exemptions* are granted for medical reasons and *waivers* for administrative reasons.

a. Exemptions from immunizations may be granted by the surgeon (staff medical officer) or commanding officer of a medical treatment facility. The written exemption will be incorporated into the individual's medical records (USAF—also record on AF Form 1711). Exemption will be based on a reliable history of significant sensitivity to an immunizing agent or other important medical contraindication. A history of sensitivity to egg or chicken protein will be taken prior to immunization. Those with a positive history may be exempted from yellow fever, typhus, or influenza immunizations. Exemption from immunizations should not be made for immunizations required under the provisions of World Health Organization (WHO) International Sanitary Regulations without overriding medical indications, since personnel not meeting international quarantine requirements may be subjected to such isolation, surveillance, or detention as the responsible national health authorities at final destination or intermediate points may prescribe. Internationally quarantinable diseases are: smallpox, yellow fever, cholera, plague, louse-borne typhus, and louse-borne relapsing fever.

b. Waivers of military immunization requirements may be granted by the appropriate Surgeon General to personnel traveling under armed forces auspices to oversea* areas for short tours (30 days or less) under conditions which make exposure unlikely. This authority may be delegated by the appropriate Surgeon General.** Only those immunizations required by the armed forces may be waived by the armed forces. Waivers will not be granted for immunizations required by WHO International Sanitary Regulations, including those for reentry into the United States, its territories, commonwealths, and possessions. For example, a technical observer going to the Panama Canal Zone for a conference at Fort Clayton for 10 days might be exempted from receiving immunization against typhoid-paratyphoid but would be required to receive smallpox immunization.

10. Categories of persons subject to immunization under this regulation. *a. Military personnel.*

(1) *All active duty military personnel except alert forces personnel.* All personnel entering on active duty in excess of 30 days will receive required routine immunizations or reimmunizations in accordance with tables II and III (columns headed "Other military personnel," "Active duty personnel" or "Basic trainees"). (The

*The words oversea and overseas, as used in this regulation, refers to all areas outside the 50 United States, the District of Columbia, and Canada.

**The Surgeon General of the Navy hereby delegates the authority to waive military immunization requirements for persons traveling under the auspices of the U.S. Navy to the medical officer on the staff of the commandants of the naval districts and river commands, Chief of Naval Air Training, Commander of the Military Sea Transportation Service, commanders of the sea frontiers, Commanders in Chief of the Atlantic and Pacific Fleets, The Commandant of the Marine Corps, commanding generals of the Fleet Marine Forces, and Commanding Officer, U.S. Naval Dispensary, Navy Department, Washington, D.C., 20390.

term "basic trainees" includes recruits, inductees, and others without prior service.) Immunizations and reimmunizations will be given as soon as possible after arrival at a training or mobilization center or, in the case of persons *not* so assigned, at the first and subsequent duty stations.

(2) *Alert forces.* Alert Forces, defined as follows, will receive immunizations in accordance with table II (column headed "Alert forces").

(*a*) *Army:* STRAC forces and personnel assigned to counter-insurgency activities.

(*b*) *Navy:* The Fleet Marine Force, personnel attached to ships in active service (except yard and harbor craft and ships assigned to the Naval Reserve for training purposes), other fleet units designated by fleet or force commanders, SEAL teams, preventive medicine units, disease vector control centers, augmentation personnel for medical units of the Fleet Marine Force and Amphibious Forces (BUMEDINST 6440 series), and surgical teams (BUMEDINST 6440 series).

(*c*) *Air Force:* Combat-ready air crews, including Ready Reserves, and their accompanying support personnel; and White Eagle personnel.

(3) *Reserve personnel.*

(*a*) Members of the Reserve who have not previously received basic immunization, and are ordered or called to active duty or active duty for training for a period of 30 days or less will receive smallpox, typhoid-paratyphoid, tetanus-diphtheria, and oral poliovirus immunization as outlined for Reserve personnel in table III prior to departing their homes or educational institutions for duty; entry on such duty will not be deferred pending the second or third dose of tetanus-diphtheria toxoid or oral poliovirus vaccine.

(*b*) Members of the Reserves, including ROTC students, entering on active duty for training which will require travel to or duty outside the United States will receive immunizations and reimmunizations as outlined for other military personnel in table II. These will be administered prior to reporting at the active duty or ACDUTRA station, when practicable, but in any event, prior to departure from the United States.

(*c*) Reserve personnel, in any status, assigned to the activities below will receive one yellow fever vaccination and one typhus vaccination if not previously received and will be reimmunized annually against smallpox and typhoid-paratyphoid fevers. Oral poliovirus vaccine will be given according to schedule "A" or "B" (table I).

1. Army: STRAC forces and personnel assigned to counter-insurgency forces.

2. Navy: Class II Organized Reserves of the U.S. Marine Corps, including mobilization teams. In addition to those immunizations above, these Marine Corps Reserve personnel will receive the basic series of cholera vaccine and the second injection of typhus vaccine required to complete the basic series.

3. Air Force: Combat-ready air crews and their accompanying support personnel and all White Eagle personnel.

Note. All requirements for alert forces apply to the above-mentioned Air Force personnel.

(*d*) Reserve personnel ordered or called to active duty or active duty for training (other than for training under section 270(b) of title 10, USC) for more than 30 days, will receive immunizations and reimmunizations in accordance with

(1) above prior to departing their home station if at all practicable; otherwise, upon reporting at duty station.

b. Military dependents.

(1) When traveling to or residing in areas outside the United States and Canada under Armed Forces sponsorship, dependents of military personnel will receive the following immunizations and reimmunizations: smallpox, typhoid-paratyphoid, tetanus-diphtheria, oral poliovirus vaccine (types I, II, and III) and influenza. Yellow fever, typhus, and cholera immunizations will be given only when required for assignment to a geographic area whose designation contains the letters Y, T, or C, respectively (fig. 1 and par. 11). While remaining in the oversea area, these dependents will be subject to reimmunizations as required for military personnel assigned to that area. Immunizations and reimmunizations will be given as for nonmilitary personnel in table II.

(2) For dependents who remain in or travel between the United States and Canada, the following immunizations are recommended on a voluntary basis: smallpox, typhoid-paratyphoid, tetanus-diphtheria, oral poliovirus vaccine, and influenza. Immunizations and reimmunizations are given as outlined for nonmilitary personnel in table III.

(3) Infants three months of age or older are required to have begun immunizations against diphtheria, pertussis, and tetanus prior to travel outside the United States and Canada. Children six months of age or older traveling outside the United States and Canada are required to have smallpox, typhoid-paratyphoid, tetanus, oral poliovirus vaccine, diphtheria, pertussis through age 5 years, oral poliovirus vaccine, and influenza (age 6 years and over) immunization plus area requirements for Y, C, or T as appropriate. Dosages of the various immunizing agents are given in tables IV and V according to the age of the child. Dependent children may receive these immunizations at ages earlier than stated or may receive other immunizations which are accepted as standard in good pediatric practice (table IV).

c. Federal civilian employees and their dependents.

(1) Federal civilian employees and their dependents who travel from or are residing outside the United States or Canada under the sponsorship of the Armed Forces will receive immunizations and reimmunizations in accordance with the requirements outlined in *b* (1) and (2) above and tables 1 through 5 as for nonmilitary personnel. These immunizations will be administered at military activities without charge upon presentation of official orders or authorizations.

(2) Federal civilian employees of the armed forces who are exposed to risk of disease such as tetanus, smallpox, or other infectious diseases associated with their occupation or service with the armed forces will be immunized with an appropriate vaccine upon the recommendation of the staff medical officer. These immunizations will be administered at military activities without charge to the employee.

(3) The activity commander, upon the recommendation of the staff medical officer, may provide immunizations against diseases which may be a significant cause of lost man-hours of work. Such immunizations will be voluntary and will be administered at military activities without charge to the employee. In other instances a charge will be made. (See AFR 160–114 and AFR 168–1.)

(4) *Army only:* The installation commander, upon the recommendation of his staff medical officer, may provide other immunizations that are officially accepted in national or local immunization programs (*for example:* influenza and poliomyelitis). These immunizations will be ad-

ministered at Army activities without charge to the employee.

d. Foreign nationals. Foreign nationals who are coming to the United States, its territories, commonwealths, or possessions under armed forces sponsorship will receive those immunizations required in paragraph 13 for entry into the United States from that country. When returning to their homelands, the foreign nationals will not be required to receive immunizations other than those cited in WHO International Sanitary Regulations or required by their countries. These immunizations will be administered at military activities without charge upon presentation of official orders or other authorization.

e. Others. All other personnel who travel from or are residing outside the United States and Canada, under armed forces auspices, will receive immunizations and reimmunizations in accordance with the requirements for military dependents in *b* above and the columns headed "Nonmilitary personnel" in table II.

11. Delineation of specific geographic areas and their general immunization requirements. Immunization requirements for travel to or duty in specific geographic areas are given in succeeding paragraphs. In those areas designated on the map (fig. 1) by letters other than "R", the letters symbolize the immunizations required for that area in addition to those designated for area "R". More than one letter, as an area designation, indicates that all immunizations symbolized by those letters are required; for example, in area CT all immunizations of area R plus *c*holera and *t*yphus immunizations.

a. Area R. Includes Canada, the United States, Mexico, islands of the West Indies (less Trinidad), but not Central America or Panama. It includes the British Isles, Iceland, Greenland, Australia, New Zealand, and all other Atlantic and Pacific islands except those designated in other areas in figure 1. Immunizations required are smallpox, typhoid-paratyphoid, tetanus-diphtheria, oral poliovirus vaccine, and influenza. (For exceptions within the United States and Canada, see par. 12 and table III).

b. Area T. Includes continental Europe, Turkey, Lebanon, Syria, Israel, Iran, Iraq and certain North African countries as outlined in figure 1. Immunizations required of all persons subject to this regulation traveling to or residing in area T are: smallpox, typhoid-paratyphoid, tetanus-diphtheria, oral poliovirus vaccine, influenza, and typhus.

c. Area CT. Includes the Philippine Islands, New Caledonia, New Hebrides, Solomon Islands, New Guinea, Guam, the U.S. Trust Territories of the Pacific and most of Asia as outlined in figure 1. Immunizations required of all persons subject to this regulation traveling to or residing in area CT are: smallpox, typhoid-paratyphoid, tetanus-diphtheria, oral poliovirus vaccine, influenza, cholera, and typhus.

d. Area Y. Includes Central America, the Republic of Panama, Panama Canal Zone, Trinidad, South America, and that part of Africa roughly south of latitude 20° N as outlined in figure 1. Immunizations required of all persons subject to this regulation traveling to or residing in area Y are: smallpox, typhoid-paratyphoid, tetanus-diphtheria, oral poliovirus vaccine, influenza, and yellow fever.

e. Area YCT. Includes Sudan, Ethiopia, Eritrea, the Somalilands, Somalia, Egypt, Jordan, Saudi Arabia, Yemen, Aden, Pakistan, India, Ceylon, and other areas as outlined in figure 1. Immunizations required of all persons subject to this regulation traveling to or residing in area YCT are: smallpox, typhoid-paratyphoid, tetanus-diphtheria, oral poliovirus vaccine, influenza, yellow fever, cholera, and typhus.

12. Vaccine doses, schedules and specific geographic requirements. *a. General.*

(1) For convenience of use, dosage schedules are tabulated in tables I, IV, and V. *Details given below should be familiar to personnel before using the tables.*

(2) All immunizing *injections* except smallpox may be given either intramuscularly (IM) or subcutaneously (SQ). Smallpox immunization is administered by the multiple pressure technic in the deltoid area. Typhoid-paratyphoid *reimmunization* may be administered intracutaneously (table I).

(3) Two or more immunizing agents will not be mixed in a vial or syringe for the purpose of permitting a single simultaneous injection. The combination of immunological preparations requires extensive research and testing and establishment of production standards to insure uniform efficacy and safety. Unauthorized mixing of immunizing agents may result in biologically and/or physically incompatible end products which are not potent immunologically or which cause enhanced adverse reactions.

(4) In the event that personnel have not been able to complete immunization series, travel will not be delayed for any except the first dose of each basic series. (For yellow fever see *b*(7) below.) Required reimmunizations will be completed prior to travel.

b. Detailed schedules and geographic requirements.

(1) *Smallpox.* See TB MED 114/NAVMED P–5052–15A/AFP 161–1–9; and paragraph 7*b*(4), AR 40–12/Navy General Order 20/AFR 161–4.

(*a*) Within area R (fig. 1): successful vaccination or revaccination every three years.

(*b*) For all other areas: successful vaccination or revaccination within one year of beginning travel and annually while in these areas.

(2) *Typhoid-paratyphoid.*

(*a*) Within the United States and Canada: basic series of two injections plus reimmunizations at 4-year intervals. Reimmunization is not required after a basic series and two reimmunizations have been received.

(*b*) For the remainder of area R and all other areas, annual reimmunization is required.

(3) *Tetanus-diphtheria.*

(*a*) In all areas basic series consisting of two primary injections and a third reinforcing injection; reimmunization *every six years.*

(*b*) Routine reinforcing and reimmunization doses of tetanus-diphtheria toxoids is 0.1 cc. *After wounding or injury,* however, tetanus-diphtheria toxoids, ordinarily will be administered in a 0.5 cc intramuscular or subcutaneous dose when the attending medical officer determines that a tetanus booster is necessary. When it appears unwise for medical reasons to administer combined tetanus and diphtheria toxoids, then tetanus toxoid alone (FSN 6505–680–2433) will be used.

(4) *Oral poliovirus vaccine.*

(*a*) Complete basic immunization consists of the properly spaced oral administration of all three types of attenuated poliomyelitis viruses. Immunization will be accomplished as outlined in tables II and III.

(*b*) Intervals between doses are reduced to meet military requirements and may not be found in the manufacturer's package insert. Reference should be made to the manufacturer's insert for determination of the number of drops to be used. When immunizations are given to inactive Reserve personnel or (N)ROTC students at nonmilitary activities, the intervals given in the manufacturer's package insert may be used instead of those given in tables II and III, at the option of the administering physician.

(*c*) Oral poliovirus vaccines will be given in distilled, unchlorinated water, in simple syrup, on a sugar cube, or by medicine dropper; all combinations of vaccines will be given immediately after fresh preparation and thorough mixing.

(*d*) Immunization with all three types of oral poliovirus vaccine is required for personnel regardless of age, who travel from or are residing outside the United States and Canada.

(*e*) Within the United States and Canada all three types of poliovirus vaccine are required for those under 30 years old.

Types I and II are required for persons 30 years or older while type III will be offered these persons on a voluntary basis. These personnel should be urged to take type III vaccine for completeness of immunity and because it is required for travel outside the United States and Canada.

(5) *Influenza.*

(*a*) Polyvalent influenza vaccine will be administered annually to all military personnel on active duty. The administration of two injections of influenza vaccine within a relatively short period of time is not considered necessary for adults. To achieve the desired level of troop immunity to influenza and to preclude unnecessary injections, active duty military personnel will be given influenza vaccine on the following schedule: All military personnel who enter upon active duty for periods in excess of 30 days will be immunized against influenza soon after entry upon active duty. An annual immunization against influenza will be given during the month of October *except for those individuals who have received such immunization during the preceding 9 months.* In the Southern Hemisphere, in the Caribbean and elsewhere the respiratory disease season may not conform to that usually seen in the Northern Hemisphere. It may be desirable to deviate from the October immunization date when such a condition exists. Ideally the immunization should be given approximately one month prior to the beginning of the respiratory disease season. See paragraph 2 for the procedure to be followed in obtaining the necessary authority for such deviation.

(*b*) Within the United States and Canada influenza vaccination will be offered to dependents of United States military personnel and to other personnel for whom military medical facilities have logistic responsibility.

(*c*) Outside the United States and Canada, influenza vaccination is required annually for all persons subject to this immunization under the provisions of this regulation.

(*d*) A history of sensitivity to egg or chicken protein will be taken prior to immunization. Those with a positive history will be exempted from this immunization.

(6) *Adenovirus vaccine.* Adenovirus vaccine will be administered to all nonprior service personnel entering active duty or active duty for training for the first time for periods in excess of 30 days. (*Navy only:* Adenovirus vaccine will be administered only to nonprior service personnel entering recruit training, unless otherwise authorized by the Chief, Bureau of Medicine and Surgery.) This program will continue uninterrupted, regardless of season of the year. Administration of adenovirus vaccine to other than nonprior service personnel as specified above is not authorized. Procurements of vaccine will be by normal supply procedures. It will be given as a single 1.0 cc subcutaneous or intramuscular dose and will be administered as soon as possible (during the first 24 hours, if feasible) after personnel have arrived at a reception station (Army, see AR 612–10), training center, recruit depot, or other first duty station.

(7) *Yellow fever.* A single immunizing dose will be given to all military personnel when they enter upon active duty for more than 30 days (other than active duty for training) unless yellow fever vaccine has been administered previously. For all persons subject to this regulation who are traveling to yellow fever areas (areas Y and YCT) or who are returning from these areas to yellow-fever receptive areas, immunization or reimmunization must be accomplished not less than 10 days (12 days for India, Pakistan, and Ceylon) or more than 6 years prior to arrival at destination. The 10-day minimum interval does not

apply to travelers to the Panama Canal Zone. Yellow fever immunization is not required for crew or passengers of vessels or aircraft passing through the Canal Zone unless such immunization is required at their destination. Yellow fever receptive areas are indicated in figure 1 and include the southeastern United States, Ryukyu Islands, U.S. Trust Territory of the Pacific Islands, Guam, Puerto Rico, and the Virgin Islands.

(8) *Typhus.* A basic single dose of typhus vaccine will be given to all personnel during basic training and to all military personnel who never have received typhus vaccine and are on active duty for more than 30 days (other than active duty for training). Upon assignment overseas or to alert forces, a stimulating dose will be given to all these military personnel. Nonmilitary personnel who have not received previous typhus immunization and who are traveling to or are residing in a typhus area (areas T, CT, or YCT) will receive two injections four or more weeks apart as a basic series. Basic series or reimmunization, if 1 year or more has elapsed since the previous typhus immunization, will be completed prior to travel to areas T, CT, YCT. In areas T, CT, and YCT annual reimmunization will be given just prior to the local typhus season when directed by the area commander in areas where typhus is a real or threatened hazard. The appropriate Surgeon General will be notified of the circumstances at any time such reimmunization is directed by the area commander.

(9) *Cholera.* Basic series consists of two injections given four or more weeks apart and is required only for movement to or duty in a CT or YCT area or in alert forces. Travel will be delayed only for the first immunization in the basic series or for a booster dose if more than six months have passed since a completed basic series or booster. Reimmunization will be required every 6 months when directed by the area commander in areas where cholera is epidemic or highly endemic and personnel are exposed to the threat of infection. The appropriate Surgeon General will be notified immediately of the circumstances whenever reimmunization is directed.

(10) *Plague.* Basic series consists of two injections given 4 or more weeks apart. Plague immunization will be administered upon the advice of the senior medical officer (theater surgeon) only upon assignment to or duty in those regions where plague is present in the human or rodent population and constitutes a hazard to personnel. The appropriate Surgeon General will be notified immediately by the senior medical officer (theater surgeon) of the circumstances at any time plague immunization is directed. Travel will be delayed only for the first immunization in the basic series or for a reimmunization dose if more than 4 or 6 months (as determined by the senior medical officer (theater surgeon)) have passed since a completed basic series or reimmunization. Reimmunization will be repeated at 4 to 6 month intervals as long as a plague hazard exists.

13. Entry or reentry of military and nonmilitary personnel into the United States, its commonwealths, territories, or possessions. *a. Smallpox.* Under this regulation, all persons entering or reentering the United States, its commonwealths, territories, or possessions are required to present evidence that they have had a successful primary smallpox vaccination not more than 3 years nor less than 8 days prior to arrival or revaccination on a date within 3 years of arrival or evidence of having had smallpox.* Because

*In normal conditions, the U.S. Foreign Quarantine Regulations permit exemption from the requirement of smallpox vaccination in respect to persons who arrive from Canada and persons who for 14 days before arrival have been only in the following countries and arrive on a carrier whose voyage has included only ports in these countries: the Bahama or Bermuda Islands, the Panamc Canal Zone, Greenland, Iceland, the Islands of St. Pierre and Miquelon, the west coast of Lower California, Aruba, Curacao, British Virgin Islands, or Jamaica. The Foreign Quarantine Regulations are applicable, however, should the quarantine officer have evidence that the traveler may have been exposed to smallpox within the 14 days prior to travel.

the success of the primary (initial) vaccination may not be evident until 6 to 8 days after vaccination, and because the incubation period of smallpox is considered to be 14 days, it is the policy of the U.S. Public Health Service that persons, including infants who arrive in the United States, its commonwealths, territories, or possessions from an infected local area and who have a primary (initial) vaccination which was administered less than 14 days before arrival, may be detained at the port of debarkation up to 14 days after arrival. Therefore, in order to avoid the possibility of detention at a United States port of debarkation, it is recommended that initial vaccination be administered at least 14 days before the expected arrival date at a debarkation point.

b. Cholera and yellow fever. These immunizations may be required, depending on the area from which the individual arrives.

(1) Cholera immunization is required more than 6 days and less then 6 months prior to entry of all persons arriving within 5 days from areas declared by quarantine authorities to be infected with cholera.

(2) Yellow fever immunization is required more than 10 days and less than 6 years prior to entry of all persons arriving within 6 days from areas infected with yellow fever, if such persons arrive in a yellow fever receptive area within the United States, or arrive in the Ryukyu Islands, the U.S. Trust Territory of the Pacific Islands, Guam, Puerto Rico, or Virgin Islands. These yellow fever receptive areas are indicated in figure 1.

14. Records of immunization. *a. Military personnel.* At the time of initial immunization of a person entering military service, SF 601 or AF Form 1711 and DD Form 737 will be initiated. These forms are official Department of Defense records and have corresponding validity. Written statements from civilian physicians attesting to immunization of these personnel and providing the dates and dosages may be acceptable as evidence of immunization. Such information may be transcribed to official records. In order to start all military personnel on a common immunologic plane, booster injections for all such completed series will be administered. Smallpox and yellow fever immunizations upon entry into the service will be given regardless of such previous immunizations. All subsequent immunizations will be recorded on these forms and the forms maintained as follows:

(1) *SF 601 (AF Form 1711).*

(*a*) In the Army and Navy, in accordance with AR 40–403 and Chapter 16, Manual of the Medical Department, U.S. Navy, respectively. Air Force installations with a mechanized Consolidated Base Personnel Office (CBPO) will use AF Form 1711 and follow the procedures as outlined in AFM 30–3, Mechanized Personnel System, Part Four, Chapter 1, Health-Immunization Records. At Air Force installations without a mechanized CBPO, SF 601 will be prepared by the unit personnel officer, in the original only, for each person in the active military service. It will be filed in the field personnel folder in accordance with AFM 35–9 and AFM 35–12.

(*b*) The status of immunization for each person will be checked by the unit personnel officer at appropriate intervals. Maintenance of personnel in a current immune status is a command responsibility (Army, see AR 40–403).

(2) *DD Form 737 (white).* This form will be prepared for each member of the armed forces and will be carried by him when traveling overseas. This form, when properly completed and authenticated, serves as a valid certificate of immunization for international travel and quarantine purposes in accordance with Article 99, WHO International Sanitary Regulations. Because the Department of Defense Seal of Immunization Certification is printed on the form, hand certification with the DOD Immunization Stamp is not required. Data may be entered by hand, rubber stamp, or typewriter. The day, month, and year will

be expressed in the order named. The day will be expressed in Arabic numerals; the month, spelled out or abbreviated using the first three letters of the word; and the year expressed in Arabic numerals either by 4 digits or by the last 2 digits. *Entries for smallpox, cholera, and yellow fever must be authenticated by the actual signature of the medical officer.* Immunizations other than smallpox, cholera, and yellow fever may be authenticated by initialing. PHS Form 731 (International Certificates of Vaccination) ordinarily need not be prepared for military personnel traveling abroad *unless traveling on passport.* In the event that a requirement for the use of this form for travel to or through a specific area becomes evident, this information will be disseminated appropriately. The appropriate Surgeon General should be notified immediately of any country which does not honor DD Form 737 in order that appropriate action can be taken. Such notification will include the name of the active duty member of the armed forces, time, and place of arrival in the country where DD Form 737 was not recognized, a photostatic or certified true copy of the certificate that was not accepted, and if possible, the name of the quarantine officer refusing recognition.

b. Nonmilitary personnel.

(1) At the time of initial immunization of nonmilitary personnel, as defined in paragraph 10 *b*, *c*, and *e*, *entries will be made only in PHS Form 731* and this form will be retained by the individual. All subsequent immunizations will be recorded on this form which may be presented as an official record of immunizations received. DD Form 737 will not be used for nonmilitary personnel under any circumstances.

(2) Completion of PHS Form 731 will be accomplished as described below for all nonmilitary personnel prior to beginning travel abroad.

(*a*) Entries must be made for smallpox, yellow fever, and cholera if required for travel. Time limits for the validity of immunizations are shown on the form and will be closely observed. Entries for "other immunizations" will be made in appropriate spaces.

(*b*) Entries on PHS Form 731 may be based on:

1. Immunizations administered at the preparing facility;

2. Transcriptions from official records; or

3. Transcriptions from written statements of civilian physicians if sufficient information is provided.

(*c*) The day, month, and year will be expressed in the order named. The day will be expressed in Arabic numerals; the month, spelled out or abbreviated using the first 3 letters of the word; the year, expressed in Arabic numerals, either by 4 digits or by the last 2 digits.

(*d*) *Entries for smallpox, cholera, and yellow fever must be authenticated by the signature of the physician and by affixing the Department of Defense Immunization Stamp.* Entries based on prior official records will have the statement added: "Transcribed from official United States Department of Defense records."

(*e*) PHS Form 731 will be obtained through normal publications supply channels. The Department of Defense Immunization Stamp (Rubber Stamp, fixed type), Immunization Certification, Department of Defense Seal (Army: FSN 7520–823–8162; Navy: FSN 7520–823–8163; Air Force: FSN 7520–823–8164) is available through medical supply channels.

15. Availability. A copy of this regulation will be kept readily available at all locations where immunizing agents are administered. Local reproduction of figure 1 and tables I through V is encouraged for use as a ready source of information.

Table I. Dosage Schedules for Basic Series and Reimmunizations for Adults [1]

Immunizing agent, size of package, potency period and Federal stock number	Basic series	Reimmunization (details given in tables II and III)
1. *Smallpox vaccine* (potency 18 months) *Freeze Dried:* *10 dose:* FSN 6505–656–0497 *100 dose:* FSN 6505–656–0498	Vaccination, to be read on 7th to 9th day and revaccination performed if required.	Same as basic.
2. *Typhoid and paratyphoid vaccine,* USP, 50 cc (potency 18 months), FSN 6505–237–8469	Two injections of 0.5 cc, four or more weeks apart.	0.5 cc SQ or IM or 0.1 cc IQ.[1]
3. *Tetanus and diphtheria toxoids,* combined, precipitated, for adult use (potency 24 months), 5 cc FSN 6505–299–8296; 30 cc, FSN 6505–864–5249	Three injections. The first two of 0.5 cc each, the second given 1 to 2 months after the first dose; third reinforcing dose of 0.1 cc approximately 12 months after the second dose.	0.1 cc at 6-year intervals; or 0.5 cc after injury or burn.
4. *Poliovirus vaccine,* live, monovalent, oral (potency 12 months) [2] *100 dose:* Type I FSN 6505–889–3513 Type II FSN 6505–889–3512 Type III FSN 6505–889–3515 *10 dose:* Type I FSN 6505–889–3511 Type II FSN 6505–889–3510 Type III FSN 6505–889–3514	Schedule A: oral route; Type I followed in 4 or more weeks by types II and III, followed in 4 or more weeks by types I, II and III. When time will not permit, the intervals may be reduced to not less than 24 days. Schedule B: oral route; Type I, followed in 6 or more weeks by type III, followed in 6 or more weeks by type II.[3]	None required. Do.
5. *Typhus vaccine,* USP, epidemic, 20 cc (potency 18 months) FSN 6505–161–7650	Military personnel: A single injection of 0.5 cc, to be followed by a second injection of 0.5 cc when assigned overseas or to alert forces. Nonmilitary personnel: Two injections of 0.5 cc each four or more weeks apart.	0.5 cc when assigned to a T, CT, or YCT area if more than 1 year has elapsed since series or reimmunization was completed.
6. *Yellow fever vaccine,* USP, 20 cc (potency 12 months) FSN 6505–162–1520	One injection of 0.5 cc of 1:10 dilution of concentrated vaccine.	Same as basic.
7. *Influenza virus vaccine,* USP, polyvalent 30 cc (potency 18 months) FSN 6505–656–0691	One injection of 1.0 cc	Do.
8. *Adenovirus vaccine,* trivalent, 30 cc (potency 6 months) FSN 6505–823–8167	One injection of 1.0 cc	None.
9. *Cholera vaccine,* USP, 20 cc (potency 18 months) FSN 6505–160–1500	Two injections: first, 0.5 cc; second, 1.0 cc, given 4 or more weeks after the first.	0.5 cc.
10. *Plague vaccine,* USP, 20 cc (potency 18 months) FSN 6505–160–7000	Two injections: first, 0.5 cc; second, 1.0 cc, given 4 or more weeks after the first.	0.5 cc.

[1] All immunizing *injections* except smallpox and the 0.1 cc typhoid reimmunization may be given subcutaneously (SQ) or intramuscularly (IM). Smallpox is administered by the multiple pressure technic in the deltoid area. Typhoid reimmunization in a dose of 0.1 cc is administered intracutaneously (IQ).

[2] See paragraph 12*b*(4)(*c*) for personnel 30 years of age or over who remain in the United States.

[3] Type III may be given after type II when type II has been administered after type I. It is emphasized, however, that the more desirable sequence is type I, followed by type III, and finally type II.

Table II. Immunization and Reimmunization Requirements for Alert Forces and for All Military and Nonmilitary Personnel Traveling to or Residing Outside the United States and Canada

Immunizing agent	Usual interval of reimmunization	Alert forces	Other military personnel	Nonmilitary personnel
1. Smallpox vaccine	1 year	X	X	X
2. Typhoid and paratyphoid vaccine	do	X	X	X
3. Tetanus and diphtheria toxoid, adult use	6 years	X	X	X
4. Poliovirus vaccine, oral types I, II, and III	None	Schedule A*	Schedule A*	Schedule A*.
5. Influenza vaccine	1 year	X	X	X
6. Yellow fever vaccine	6 years	(a)	(a)	(b)
7. Typhus vaccine, epidemic	1 year**	(c)	(c)	(d)
8. Cholera vaccine	6 months**	(e)	(f)	(f)
9. Plague vaccine	do			
10. Adenovirus vaccine	None			

[a] All military personnel will receive a basic yellow fever immunization. Immunization or reimmunization is required within 6 years if going to or stationed in a Y or YCT area (fig. 1).

[b] Immunization or reimmunization is required within 6 years if going to or residing in a Y or YCT area (fig. 1).

[c] One orienting dose of typhus is required for all military personnel. The basic series is completed by a second injection when assigned to alert forces or outside the United States or Canada. The basic series or reimmunization is required within 1 year prior to travel to area T, CT, or YCT (fig. 1 and par. 12b(8)).

[d] Typhus basic series (2 injections) or reimmunization within 1 year is required for nonmilitary personnel prior to travel to a T, CT, or YCT area (fig. 1).

[e] Cholera basic series is required. Immunization or reimmunization within 6 months is required only if traveling to or stationed in a CT or YCT area (fig. 1).

[f] Cholera immunization is required within 6 months only if traveling to or residing in a CT or YCT area (fig. 1).

X Indicates that immunization is required.

* See table I. Prior completion of either schedule A or B fulfills this requirement.

** When directed by area commander.

Table III. Immunizations and Reimmunizations Required Within the United States and Canada Excluding Alert Forces I†

Immunizing agent	Usual interval of reimmunization	Active duty personnel	Reserve personnel	Basic trainees	Nonmilitary personnel
1. Smallpox vaccine	3 years	X	X	X	X*
2. Typhoid and paratyphoid vaccine	4 years[a]	X	X	X	X*
3. Tetanus and diphtheria toxoid, adult use.	6 years	X	X	X	X*
4. Poliovirus vaccine, oral types I, II, and III.	None	Schedule B** [b]	Schedule B** [b]	Schedule A**	Schedule B* ** [b].
5. Influenza vaccine	1 year	X	(c)	X	X*
6. Yellow fever vaccine	None	1 injection	(d)	X	
7. Cholera vaccine	do		(e)		
8. Typhus vaccine, epidemic	do	1 injection	(f)	1 injection	
9. Plague vaccine	do				
10. Adenovirus vaccine	do			X	

[a] No further typhoid-paratyphoid reimmunization required after basic series and two reimmunizations have been completed while remaining in the United States or Canada.

[b] Type III oral poliovirus vaccine optional but recommended for persons 30 years of age or older.

[c] Influenza vaccination required for Reserve personnel on active duty for 30 days or more regardless of purpose.

[d] Yellow fever vaccination required of certain Reserve personnel. See paragraph 10a(3)(c) of basic regulation.

[e] Cholera vaccine basic series completion required for certain Reserve personnel. See paragraph 10a(3)(c)2 of basic regulation.

[f] Complete basic series of typhus vaccine, epidemic, required for certain Reserve personnel. See paragraph 10a(3)(c)2 of basic regulation.

*May be received on a voluntary basis.

**See table I. Prior completion of either schedule A or B fulfills this requirement.

†The requirements may be altered when applied to groups being studied by the Armed Forces Epidemiological Board or in other field studies approved by the appropriate Surgeon General.

Table IV. Dosage Schedules of Basic Series of Immunizations for Children

Immunizing agent	1–5 months	6 months–5 years	6–9 years [a]
1. Smallpox vaccine	Vaccination, read on 7th to 9th day; revaccination performed if required.	Vaccination, read on 7th to 9th day; revaccination performed if required.	Vaccination, read on 7th to 9th day; revaccination performed if required.
2. Typhoid and paratyphoid	Not given	0.2 cc, followed in 4 or more weeks by 0.2 cc.	0.3 cc followed in 4 or more weeks by 0.3 cc.
3. Tetanus, diphtheria and pertussis, combined (pediatric).	0.5 cc at one month intervals for three doses; reinforcing dose of 0.5 cc given 7 months after 3d.	0.5 cc at one month intervals for three doses; reinforcing dose of 0.5 cc given 7 months after 3d.	Not given. Give DT (pediatric).[b]
4. Tetanus and diphtheria toxoids (pediatric).	Not given	Not given	For booster: 0.5 cc. For primary immunization: 0.5 cc at one month intervals for three doses; reinforcing dose of 0.5 cc given 7 months after 3d.
5. Poliovirus vaccine, oral, types I, II, and III.	Schedule B (see table I)	As for 1–5 months	As for 1–5 months.
6. Influenza vaccine	Not given [c]	Not given [c]	Two doses, 0.25 cc each not less than 2 months apart.[a]
7. Yellow fever vaccine	Not ordinarily given	0.5 cc	0.5 cc.
8. Cholera vaccine	Not given	0.1 cc, followed by 0.3 cc in 4 weeks.	0.3 cc followed by 0.5 cc in 4 weeks.
9. Typhus, vaccine, epidemic.	do	0.1 cc, followed by 0.3 cc in 4 weeks.	0.3 cc followed by 0.5 cc in 4 weeks.
10. Plague vaccine	do	0.1 cc, followed by 0.3 cc in 4 weeks.	0.3 cc followed by 0.5 cc in 4 weeks.
11. Adenovirus vaccine	do	Not given	Not given.

[a] Age group expanded to 6–12 years for influenza vaccination.
[b] Children 10 years of age or older will be immunized according to adult schedule (table II) using tetanus-diphtheria vaccine (adult type).
[c] Influenza not required for children less than 6 years old. In years of expected high incidence, vaccination is recommended for children aged 3 months to 1 year with primary immunization consisting of two 0.1 ml subcutaneous injections given 1–2 weeks apart and a booster consisting of 0.1 ml given 2–3 months later.

Table V. Reimmunization Dosage for Children [a]

Immunizing agent	6 months–5 years	6–9 years [b] [c]
1. Smallpox vaccine	Same as basic	Same as basic.
2. Typhoid and paratyphoid	0.2 cc	0.3 cc.
3. Tetanus, diphtheria, and pertussis, combined (pediatric)	0.5 cc	Not given.
4. Tetanus and diphtheria toxoids (pediatric)	Not given	0.5 cc.
5. Poliovirus vaccine, oral, types I, II, III	Not required	Not required.
6. Influenza vaccine	Not given	0.25 cc.
7. Yellow fever vaccine	Not required	0.5 cc.
8. Cholera vaccine	0.3 cc	0.5 cc.
9. Typhus vaccine, epidemic	0.3 cc	0.5 cc.
10. Plague vaccine	0.3 cc	0.3 cc.

[a] *Reimmunizations* (booster immunizations) are not necessary in children less than 6 months old.
[b] The age group is extended to 12 years for influenza vaccination.
[c] Children 10 years of age or older will be immunized according to adult schedule (see Table I, II, and III).

OUTLINE MAP OF THE WORLD

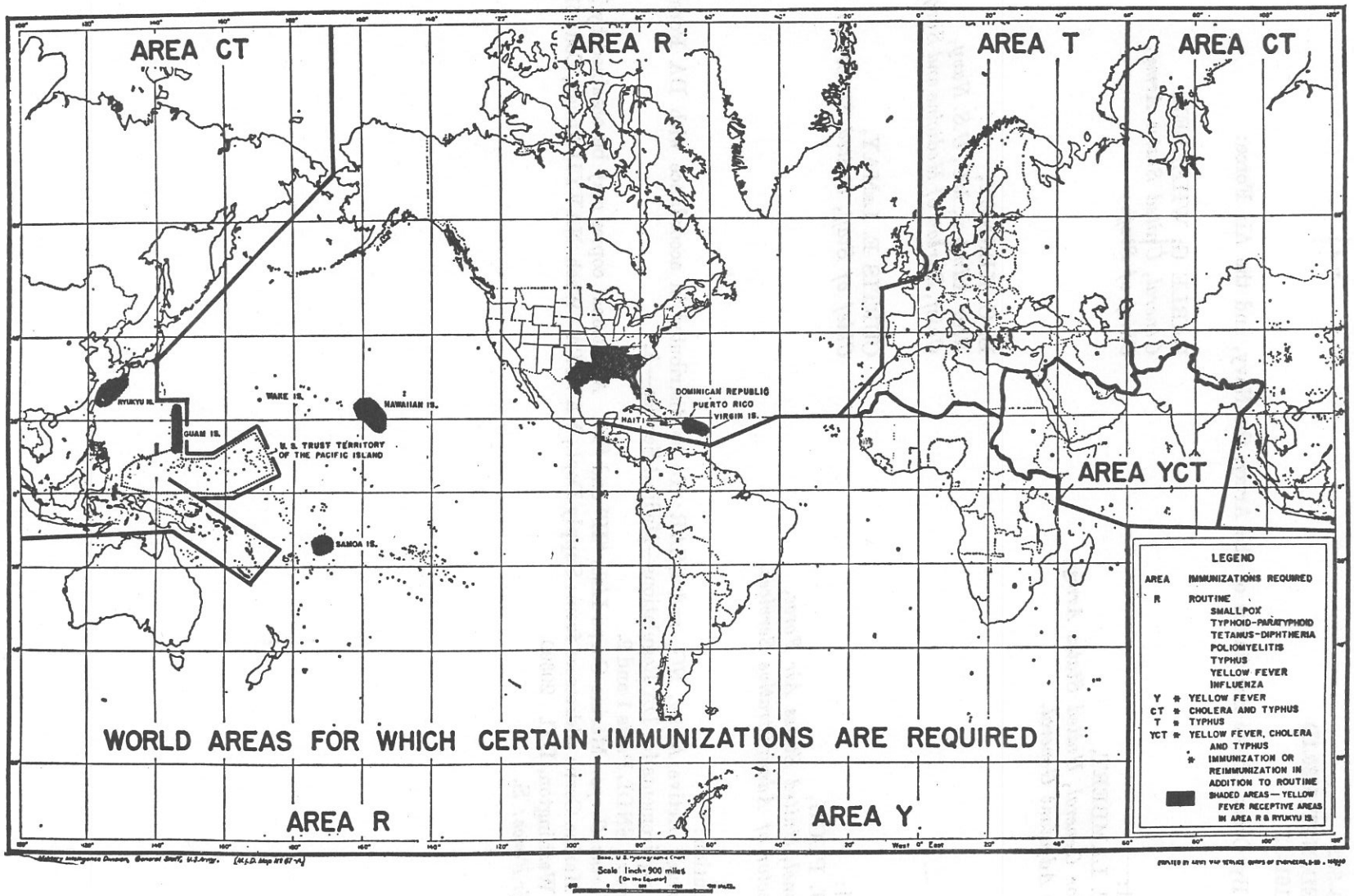

Figure 1

AR 40–562
BUMEDINST 6230.1D
AFR 161–13

By Order of the Secretaries of the Army, the Navy, and the Air Force:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

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Major General, United States Army,
The Adjutant General.

E. C. KENNEY,
Rear Admiral, MC, U.S. Navy,
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APPENDIX VI

DEPARTMENT OF THE NAVY
Bureau of Medicine and Surgery
Washington 25, D.C.

BUMED 6230.1C SUP-1
BUMED-721-BFG:rd
19 April 1963

BUMED INSTRUCTION 6230.1C SUP-1

From: Chief, Bureau of Medicine and Surgery
To: All Ships and Stations

Subj: Smallpox and typhoid reimmunization requirements

1. Purpose. To promulgate smallpox and typhoid reimmunization requirements for certain personnel.

2. Action. Personnel assigned to activities indicated below shall be reimmunized annually against smallpox and typhoid-paratyphoid fever regardless of geographical area in which located:

a. Fleet Marine Forces, organized Marine Corps Reserve units including mobilization teams.

b. Fleet units designated by Fleet or force commanders.

c. U.S. Navy seal teams.

d. U.S. Navy preventive medicine units and disease vector control centers.

e. Surgical teams (BUMEDINST 6440.1 series NOTAL).

f. Augmentation personnel for medical units, Fleet Marine Force and Amphibious Forces (BUMEDINST 6440.2 series NOTAL).

A. S. CHRISMAN
Acting

Distribution:
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APPENDIX VII

RECORD OF EMERGENCY DATA

SEE INFORMATION ON REVERSE BEFORE MAKING ENTRIES

SHIP OR STATION

1. WIFE OR HUSBAND	ADDRESS

2. NAMES OF CHILDREN	ADDRESS	MARRIED YES	MARRIED NO	SEX	DATE OF BIRTH

3. FATHER	ADDRESS

4. MOTHER	ADDRESS

5. ADULT NEXT OF KIN NOT NAMED IN ANY OTHER ITEM	ADDRESS

6. ALL PERSONS RECEIVING MORE THAN 50 PERCENT OF THEIR SUPPORT FROM ME (OTHER THAN WIFE OR CHILDREN UNDER 21)	ADDRESS	RELATIONSHIP	DATE OF BIRTH

7. PERSON(S) NAMED ABOVE WHO ARE NOT TO BE NOTIFIED DUE TO ILL HEALTH	ADDRESS

DESIGNATIONS

		NAME	ADDRESS	RELATIONSHIP
8. BENEFICIARY FOR GRATUITY PAY IN EVENT THERE IS NO SURVIVING SPOUSE OR ELIGIBLE CHILD(REN). NAME PARENTS OR BROTHERS OR SISTERS ONLY (10 USC SECTIONS 1475 - 1480).				
9. BENEFICIARY OR BENEFICIARIES FOR UNPAID PAY AND ALLOWANCES (10 USC SEC 2771) WHICH INCLUDES ENLISTED MEMBERS' SAVINGS DEPOSITS. PERCENT OF SHARES MUST TOTAL 100%.	%			
	%			
10. PERSON TO RECEIVE ALLOTMENT OF PAY IF MISSING OR UNABLE TO TRANSMIT FUNDS.	PERCENT OF PAY EACH MO.			

11. INSURANCE POLICIES IN FORCE INCLUDING USGLI AND NSLI *(Agencies to be notified in case of death in active service)*

FULL NAME AND ADDRESS OF COMPANY	ADDRESS OF OFFICE RECEIVING PAYMENT OR HOME OFFICE	POLICY NO.

12. SIGNATURE AND TITLE OF WITNESS *(If non-military, give address)*	13. SIGNATURE OF DESIGNATOR	DATE SIGNED
		SOC. SEC. NO. *(Officers only)*

NAME OF DESIGNATOR *(Last, first, middle)*	FILE/SERVICE NO.	GRADE/RATE	BRANCH OF SERVICE

RECORD OF EMERGENCY DATA - NAVPERS 601-2 (New 4-61)

INSTRUCTIONS

GENERAL.

All items on this form must be completed and maintained current by all officers and enlisted personnel in accordance with BuPers Manual, Article B2312. If necessary, continue any item in "Remarks," but specify the particular item being continued. Entry of other useful information in connection with emergency data such as location of will, safety deposit boxes, marriage data (date and place of marriage and termination of any prior marriage), emergency notification, etc., should be made under "Remarks."

NOTIFICATION OF NEXT OF KIN.

In the event you, the designator, should die, the persons or agencies named in items 1, 3, 4, 5, and 11 will be notified unless item 7 shall indicate a person or persons NOT to be notified. Children named in item 2 also will be notified if no spouse survives or if they are children of other than the present spouse.

Should you become missing or critically or seriously ill, or incapacitated to the extent that you cannot notify them (except in psychotic disorders, major disfigurements, etc., when only primary next of kin are informed), the persons named in items 1, 3, 4, and 5 will be notified unless item 7 shall indicate a person or persons not to be notified. Children named in item 2 also will be notified if no spouse survives or if they are children of other than the present spouse.

DESIGNATIONS.

a. Gratuity Pay (Item 8). The succession of eligible survivors as set forth in the "Servicemen's and Veterans' Survivor Benefits Act" (10 USC Sect. 1475-1480) is as follows: (1) Spouse; (2) Children (without regard to their age or marital status) in equal shares; (3) Parents or brothers or sisters (including those of halfblood and those by adoption), when so designated; (4) Parents in equal shares; or (5) Brothers and sisters (including those of halfblood or those by adoption) in equal shares.

Note: The payment to either category (4) or (5) is in the event that a designation is not made under category (3). The term "parents" includes "natural parents," "stepparents," "adoptive parents" and persons who stood in "loco parentis" to the designator for a period of not less than 1 year at any time prior to the designator's entry upon active service.

b. Unpaid Pay and Allowances (Item 9). Savings deposits and interest thereon are amounts due in your pay and allowance account, and upon your death, all such amounts will be paid to any beneficiary or any beneficiaries whom you designate in item 9 without regard to any will you may execute before or after the date of designation. Any person or persons, even though not related to you, may be designated in item 9, and once such a designation has been made, it is binding until superseded by the completion of a later NavPers 601-2.

c. Allotment of Pay (Item 10). The "Missing Persons Act" provides that pay and allowances continue to accrue to the pay account of any service member for the period he is missing or captured and may be paid to the dependents for support. This item reflects your desires and is used as a guide in the disposition of your pay. Allotments are not registered in excess of 80% of the member's total pay and allowances. Allotments to dependents and insurance companies initiated prior to entering a missing status are continued in effect unless unusual circumstances indicate changes.

REMARKS: